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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS

New Selective Service Ages (20-45) Will Make Sixteen Thousand Physicians Available for Military Service.—The United States is at war with two strongly militarized nations. The armed forces of the United States must now be fully and promptly implemented. Six physicians are necessary to care for the medical needs of every one thousand soldiers; therefore, with each million soldiers, six thousand physicians will be required for the Army alone. Our present Army consists of 1,480,000 men, and its Medical Corps includes 10,000 physicians, 2,300 dentists, 600 veterinarians, 1,000 lay officers in the Medical Administrative Corps, 200 Sanitary Corps officers, and an enlisted personnel of 109,000 soldiers.

If, then, during the year 1942, the Army enrollment is extended to 4,000,000 men, as may happen, there will be an increase in the Medical Corps proportionate to the existing military establishment. The physicians who are required for our present and prospective armed forces in Army and Navy are drawn from civil life, and will come largely from the Selective Service age-period group of 20-45 years.

Any physician in that group (of 20 to 45 years) may be inducted into military service. If his qualification record is on file, he can probably enter the service as a medical officer; but if he has neglected to enroll with the proper authorities, he may find himself initiated as a soldier of the line, to remain in that capacity until such time as a transfer to the Medical Corps can be made. During the line-soldier period he would receive only the pay of a soldier in the ranks, and be called upon to function as such.

The above facts indicate why every physician in the age-period mentioned should promptly send his name to the U. S. Procurement and Assignment Service for Physicians, of which Major Sam C. Seeley, M.D., is the Executive Director. The questions listed on the informative blank are printed in this issue*, and a full page usuable blank of the same appears in the *Journal of the American Medical Association* for December 27, on page 2255.

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* A later bulletin dated January 16, 1942 stated a new form blank will be issued, in lieu of blank on page 28.

Note. January 19, 1942.—See also important notices on p. 51.

Since male citizens within the period 20 to 65 must register with the Selective Service Boards, the blank referred to above should be filled in promptly by every physician coming within that age group. But such early enrollment is particularly urged for all physicians between the ages of 20 and 45. Procrastination may work for awkward and unpleasant situations.

* * *

Procurement and Assignment Services For Physicians, Dentists and Veterinarians.—This new Assignment service, designed to promote the prompt and efficient enrollment of physicians, dentists and veterinarians in the Medical Corps of the armed services, was inaugurated by President Roosevelt on October 3, 1940. Its liaison and executive officer is Major Sam F. Seeley, M. C., who may be addressed: Dr. Sam C. Seeley, Procurement and Assignment Service, New Social Security Building, 4th and C Streets, S. W., Washington, D. C. The new department has official standing in the Government and will work with other constituted authorities that have responsibilities in the full development of the Medical Corps of Army and Navy.

At the outbreak of the present war the Medical Corps of the Army had on its roster a total of 8,983 reserve officers. In addition, there are 1,250 physicians who hold commissions in the Regular Army and 1,232 who are officers in the National Guard. It was at first estimated that for the Army, with its present enrollment of 1,480,000 men there would be needed annually about 3,200 officer replacements in the Medical Corps. But this was all prior to December 7, 1941, before the United States had war thrust upon it.

The need of adequate medical personnel is shown in the announcement on December 31, 1941, by Brigadier General Lewis B. Hershey, Director of Selective Service, in which deferment and other provisions available to medical students, are outlined.*

* * *

A. M. A.'s Recent Survey Now of Great Value.—The work which the American Medical Association carried on during the last year, in conjunction with the constituted state medical societies and their component county units—designed to gather and properly compile informative data concerning the qualifications of physicians in every state of the Union—will now be put to good and immediate use by the Procurement and Assignment Service. The forethought of the A. M. A. authorities, therefore, in instituting its survey, makes it possible for organized medicine in the present emergencies, to be of real and large service to the Government. Continued cooperation by physicians has been requested and will be given.

* For news item see page 36.

CIVILIAN DEFENSE ORGANIZATION IN CALIFORNIA

California Civilian Defense.—The work to be performed by physicians during war emergencies will increase in proportion as grave conditions arise. This is particularly true for members of the medical profession who reside in states bordering on the Pacific and Atlantic Oceans.

In California, many physicians have found it rather difficult to get a clear understanding of the constituted agencies carrying on civilian defense activities. This confusion probably arose some two years ago, through the action by Governor Olson who, on his own initiative, appointed a State Council of Defense, consisting of some fifty citizens, of which only one was a physician—Charles A. Dukes, M. D., of Oakland.

When the Legislature met in Sacramento in January, 1941, the Governor's procedure became a subject of controversy. After the legislative battle was over, a newly-constituted legislative California State Council of Defense, to succeed the former body and consisting of thirty citizens, was brought into being. In this new group, the medical profession again had only a single representative, the mantel this time falling on the shoulders of the President of Stanford University, Ray Lyman Wilbur, M. D.

* * *

National Office of Civilian Defense.—Subsequent to these California activities, the national Office of Civilian Defense was created by President Roosevelt, with F. H. La Guardia, Mayor of New York City, as U. S. Director. George Baehr, M. D., Washington, D. C., is its Chief Medical Officer, and the regional medical officer is Wallace D. Hunt, M. D., with offices at 233 Sansome Street, San Francisco. Doctor Hunt is on transfer from the U. S. Public Health Service, and the Ninth Civilian Area, which he supervises, includes the same states as the Ninth Army Corps Area, (California, Oregon, Washington, Nevada, Utah, Montana, and Idaho). The above information is given as a matter of record and for easier reference.

* * *

State and Local Departments of Civilian Defense.—Just as there is a national Office of Civilian Defense, or department, so also in every state and in most counties of each commonwealth, and in larger municipalities, similar bodies with functions designed to meet the needs of their respective areas, have been organized.

In California, the Office of Civilian Defense now works through the California State Council of Defense—the body authorized by the last Legislature. The medical activities of the State Council come under the supervision of one of its major committees, (Committee on Health, Welfare and Consumers' Interests), and this committee in turn has delegated many of the health

functions to a Sub-committee on Health, of which Bertram P. Brown, M. D., Director of the California State Department of Public Health, is chairman. To look after health needs which may be indicated in civilian defense, Doctor Brown, in November last, appointed two committees, one to function for the northern, and the other for the southern section of California. Each of the committees, as originally planned, was to consist of one doctor of medicine, one doctor of osteopathic medicine, one representative of the hospitals, one representative of the state nursing group, and one representative of the state public health nurses organization.

The authorities of the State Council of Defense then appointed, as representatives of the medical profession, O. D. Hamlin, M. D., of Oakland, and Wallace Dodge, M. D., of Los Angeles.

At the time these comments are written, it is understood that the two committees referred to will receive several additional members.* It has also been stated that the central office of the State Council of Defense of California will be located in Sacramento, (at Room 305, of the State Capitol, Sacramento).

County and City Councils of Civilian Defense will probably be contacted in due course, through the headquarters office in Sacramento.

* * *

Medical Preparedness Items in this Issue.—In the department of the C. M. A. Committee on Medical Preparedness of the current number, much information is given concerning measures related to civilian defense.† Readers are advised to scan the items, because every physician in California may have occasion to use some of the information there appearing. For example, transportation of physicians during black-outs, procedures in hospitals, and emergency field unit responsibilities, are problems in point.

CALIFORNIA AND WESTERN MEDICINE will continue to grant page space to medical preparedness items which may be of possible service to members of the California Medical Association, in the hope to make more certain, efficient medical service in any emergencies which may arise.

* * *

ON VARIOUS TOPICS

Annual Secretarial Conference of the California Medical Association.—In California during recent years, one of the high lights of organized medicine meetings has been the annual joint conference of officers, committee chairmen, and A. M. A. delegates of the California Medical Association, held with the secretaries of the component county societies. This year's conference is scheduled for Sunday, January 18th, the place of meeting to be the Sir Francis Drake Hotel in San Francisco.

Heretofore, the joint session has been held on Saturday. Sunday has been chosen for the January 18, 1942, meeting, because it was thought it may be a more convenient time for attendance by county society officers and state committeemen. The secretaries are the official representatives of the component county units, but other officers are also invited to attend. Meeting notices will give full information.‡

This year, with its war emergencies and responsibilities, the joint conference should bring forth much information of value, and through the county representatives and other officers who will be in attendance, the messages on best methods of procedure can be carried to all portions of the State, and so make for more effective service throughout the length and breadth of California. In days such as the present, physicians also have much to learn. Through mutual conference and counsel, best methods of action can be determined.

* * *

Official County Reports in December Issue.—Were you a reader who scanned the report of his county society for the year 1941, which appeared in the December issue, on pages 316-325? And, if you are a county society officer or a member of a program committee, did you take the time needed to glance over the reports submitted by other county units, and make note of what their members are doing, and consider whether some of the procedures would be applicable to your own county society? If not, may the suggestion be made that this should be done at some convenient time?

* * *

C. M. A. Annual Session: Del Monte, May 4-7.—The C. M. A. Committee on Scientific Work, at a recent joint session with the twelve scientific sections of the Association, outlined the programs for the general and section meetings that will be held on May 4-7, 1942, which will commence officially on the first Monday of that month.

On Sunday, May 3rd, affiliated organizations will carry on their usual meetings and activities.

The new pavilion, consisting of six commodious meeting rooms—which is being erected by the Hotel Del Monte at a cost of almost $40,000, and located immediately adjacent to the East Wing, near-by the putting green, and to the right as one approaches the main hotel building—is rapidly approaching completion. These new rooms will be available for the Woman's Auxiliary during the morning hours, at which time the Association is holding its general sessions in the auditorium in the main building, and in the afternoons, they will be given over for use by six of the C. M. A.'s scientific sections. This relief from the crowded meeting rooms of the larger sections will be most welcome.

Once again, request is made that all physicians who can present scientific exhibits or medical

* New appointments include:

For Northern Committee, Harold A. Fletcher, M.D., of San Francisco, and Charles E. Smith, M.D., of San Francisco. (Dr. Fletcher is chairman of the C. M. A. Committee on Medical Preparedness, and Dr. Smith is a member of the California State Board of Public Health).

For Southern Committee: Lewis A. Alesen, M. D., of Los Angeles and A. Elmer Belt, M. D., of Los Angeles. (Dr. Alesen is secretary of the Los Angeles County Medical Association, and Dr. Belt is president of the California State Board of Public Health).

† See page 24.

‡ For preliminary program see page 23.

films will inform the Association Secretary, who is chairman of the Committee on Scientific Program. Special appeal is made to faculty members of the medical schools, since their departments have valuable material that would be much appreciated by visiting physicians. The medical and surgical films will be presented in the copper cup room, and the exhibits will probably be housed in the new garden room of the main building.

* * *

Postgraduate Conferences in 1942.—In the current number of CALIFORNIA AND WESTERN MEDICINE, on the pages given over to the Committee on Postgraduate Activities*, appears among other notices, an item concerning the two full-time representatives of the California State Department of Public Health, whose services are available for clinics, consultations, and talks, on problems in pediatrics, dermatology and syphilology. No local expenses are involved for the component county societies, whose members may wish to make use of these facilities. Owing to war conditions, it will be difficult to secure guest speakers from the medical schools and metropolitan centers for appearance at postgraduate conferences and refresher courses, and the services of the State Board representatives, who have had extensive clinical and other training, will be all the more appreciated.

The C. M. A. Committee on Postgraduate Activities, therefore, urges county societies to make use of the services of Doctors Sinclair and Scholtz. You will not regret such action.

CALIFORNIA AND WESTERN MEDICINE IS NOW PRINTED IN LOS ANGELES

As the official journal of the California Medical Association, there appeared in November, 1902, from the press of the James H. Barry Company in San Francisco, Number 1 of Volume 1 of the CALIFORNIA STATE JOURNAL OF MEDICINE, a monthly publication that took the place of the bound *"Annual Volume of Transactions"* of the "Medical Society of the State of California." In a subsequent year, at the suggestion of the late W. E. Musgrave, then editor, the JOURNAL was given its present name, CALIFORNIA AND WESTERN MEDICINE.

In another year, in order to conform with a general movement among constituent state units of the American Medical Association, the "Medical Society of the State of California" was renamed, to become the "California Medical Association."

During the last several years, the printing costs of the OFFICIAL JOURNAL have been a subject of considerable discussion at meetings of the House of Delegates, leading the Council to secure new bids for the printing and production of the magazine; and finding that a saving in money could be effected if the printing was done in Los Angeles, a change in printer was authorized.

These comments are mentioned, not only to express appreciation for the many years of efficient and faithful cooperative service by the James H. Barry Company of San Francisco, but also to express the hope that the Wolfer Printing and Engraving Company of Los Angeles will be able to carry on in equally pleasant relationship.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 21.

EDITORIAL COMMENT†

TREATMENT OF DIABETES MELLITUS

In the last few years, an attempt, deliberate or otherwise, has been made to undermine the treatment of Diabetes Mellitus. Various articles appearing in the literature have, by inuendo, at least, indicated that that status of the disease, usually known as "controlled", is no longer necessary. Suggestions have been made that hyperglycemia may be permitted, and glycosuria allowed, as long as the alkali reserve remains normal and ketonuria absent. As a result, marked laxity in treatment has been not only suggested but actually condoned.

It seems to me, however, that the primary object of treatment of any disease is the restoration of the patient to as near a normal state as possible. The individual suffering from impairment of cardiac function is started on a régime, which is intended to overcome the hazardous condition in which he has been placed and to restore him to as useful an existence as is medically possible. The patient suffering from an infectious disease is given chemotherapy in an attempt to overcome the infection, and thereby to permit the sufferer to return to a normal status.

The person affected with Diabetes Mellitus is an individual with a serious disease—a killing disease, if not treated, and a crippling disease if treated improperly.

Statistics accumulated prior to the Insulin Era more than amply confirm such a statement, for at that time sixty to eighty per cent of diabetics died of coma, and the remaining group could look forward only to a premature senility and the serious complications thereby produced. It was then thought that the discovery of insulin would result

* See page 38.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

in the complete elimination of the ill effects of the disease, and that sufferers, if permitted to use such a substance, would be restored to the status of normal individuals. Apparently the varying secretion of insulin from the normal pancreas, in response to the need therefor, either was not thoroughly understood, or, for the most part, was overlooked. Insulin proved to be not necessarily ideal, because hyperglycemia and glycosuria fluctuated in spite of frequent administration; but it was of enormous benefit. And the discovery of protamine zinc insulin, with its prolonged activity, added greatly to the possibility of improvement in the physical condition of the diabetic. Yet, in spite of the marvelous results produced by insulin and its derivatives, a dietary régime has been, and continues to be the foundation upon which the treatment of diabetes is builded. It should be emphasized, too—as Allen suggested over two decades ago—that the total caloric intake of the patient is of fundamental importance in properly adjusting the dosage of insulin. The distribution of the required number of calories among the three major types of food is in reality probably of minor significance. A diabetic diet is a priori a measured diet. It follows that, unless the diabetic diet is properly utilized, its prescription becomes an absurdity, unnecessarily burdening one who is almost overwhelmed with a serious disease, with picayunish arithmetic. It follows, too, that if hyperglycemia and glycosuria are not reduced to a minimum, the caloric utilization must vary tremendously. Moreover, the morale of the patient, already low, is still further reduced. The obvious is as equally apparent to him as to those who presumably are better trained. The first reaction is that of wonderment as to what constitutes control, and what effort is being made to reduce the severity of the disease which the sufferer knows is serious.

Until scientifically proven data adequately support this lax method of treatment, the wiser procedure is to retain the more fundamental concepts applicable to any disease: namely, to introduce such therapeutic procedures as will enable the patient to approximate the normal individual both mentally and physically. This seems imperative in diabetes; for "diabetic patients, treated just sufficiently to keep them out of acute trouble for a few years, constitute the reservoir from which are drawn the great mass of complications which cause most diabetic deaths today."

384 Post Street.

H. Clare Shepardson,
San Francisco.

FLEMING'S "LYSOZYME"

In 1922 Fleming discovered an antiseptic substance in egg white, minute quantities of which are capable of killing and dissolving certain bacteria. He afterwards found that this "lysozyme" is widely distributed in the animal body, being found in particularly high concentration in saliva, tears and duodenal secretions. The protein nature of this salivary antiseptic was subsequently established by American investigators [1] and the substance afterwards isolated in crystalline form.[2] It was noted by the English biochemists that as a result of the action of this natural antiseptic, reducing substances are set free from susceptible bacteria, suggesting that "lysozyme" should be classed as a carbohydrate.

Epstein and Chain [3] of Oxford University have recently confirmed this conclusion by isolating and identifying the lysozyme-susceptible substrate in bacterial cells. Massive growths of susceptible bacteria were dissolved in antiformin or formamide, and factionated with alcohol or acetone. The only fraction found susceptible to lysozyme was a starch-like muco-polysaccharide, non-dialysable through cellophane or collodion membrane. On incubation with lysozyme this muco-polysaccharide is first depolymerized into complex dialysable sugars which are afterwards hydrolyzed to form relatively simple hexoses.

The Oxford biochemists found that the rate of formation of N-acetylhexosamine furnishes a convenient method of titrating lysozyme in body fluids, control tests being run with heat-inactivated materials. Thus, in one series of titrations cat saliva yielded 2.4 arbitrary units of the hexosamine when acting upon a standard quantity of the susceptible muco-polysaccharide. Human saliva yielded 1.7 units, human tears 4.2 units and egg-white 4.7 units. It is of interest that the low lytic titer of human saliva was increased to 3.75 units by acidulation, suggesting that swallowed saliva may have a continued antiseptic action in the stomach.

The British bacteriologists found that the susceptibility of different microbic species varies directly with their muco-polysaccharide content. B. subtilis, Br. abortus, and many Sarcina, for example, are relatively rich in this starch-like material, and are all readily killed or dissolved by salivary lysozyme. In contrast Staph. albums, B. coli and B. pyocyaneus contain practically no muco-polysaccharide, and are all resistant to the salivary antiseptic. With certain intermediary bacteria neither lysozyme itself nor trypsin by itself is capable of dissolving the bacterial cell. Complete lysis, however, is effected by a combined action of these two enzymes. This finding suggests a continued antiseptic rôle of salivary lysozume after reaching the small intestine. Whether or not the duodenal lysozyme is of salivary origin, however, has not yet been determined.

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ORIGINAL ARTICLES

DUODENAL ULCER: INDICATIONS FOR AND EXTENT OF PARTIAL GASTRECTOMY*

VERNE C. HUNT, M. D.
Los Angeles

WITH the concept of the surgical duodenal ulcer undergoing some revision during recent years, ideas have been revised regarding the objectives of surgical treatment, and this has resulted in an insidious change in the methods by which those objectives might be served most advantageously. The results of careful and competent medical management are now sufficiently good in the majority of cases of uncomplicated duodenal ulcer, and the results of surgical procedures in the past have been sufficiently unsatisfactory in the absence of one complication or another, so that today the uncomplicated duodenal ulcer is seldom considered a surgical lesion. In other words, the indications for surgical intervention have become quite universally and sharply limited to the complications of the ulcer.

INDICATIONS FOR SURGICAL TREATMENT OF DUODENAL ULCER

Acute perforation of an ulcer constitutes an absolute and urgent surgical condition, with the prospects for recovery greatly enhanced by early surgical closure of the perforation. It is worthy of emphasis that even though radical operations, curative in purpose so far as the ulcer is concerned, have been advocated, the surgeon's responsibility is solely that of closure of the perforation. That ulcer symptoms frequently recur, and that a subsequent surgical procedure is often necessary seldom, if ever, justifies a more radical operation in the surgical management of an acute perforation.

Protective perforation of a duodenal ulcer occurs much more frequently than does acute perforation into the free peritoneal cavity. Experience has proved that many ulcers which perforate onto the pancreas become penetrating ulcers, and usually are not amenable to medical treatment but ultimately require surgical consideration. With the narrowing of indications for surgical intervention in duodenal ulcer, and the elimination of the uncomplicated ulcer from the field of surgery, the penetrating ulcer has become a relatively more frequent lesion with which the surgeon has to deal.

The bleeding duodenal ulcer presents a serious problem to both the internist and the surgeon, and the question usually arises as to whether medical and nonsurgical methods of management shall be relied upon, or whether an operation shall be performed. It is a commonly held and frequently expressed opinion that hemorrhage is rarely a fatal complication in duodenal ulcer. It is known that bleeding occurs in from 20 to 35 per cent of the cases of duodenal ulcer. In many of these cases the bleeding is manifested through the persistence of a secondary anemia, and the presence of occult blood in the stool. As a rule these cases respond to careful medical management, and seldom, in the absence of massive hemorrhage, require surgical consideration. It is the massive exsanguinating hemorrhage which constitutes a serious emergency. Allen and Benedict and Goldman have reported death in from 10 to 15 per cent of persons who experience massive hemorrhage from a duodenal ulcer. These authors, among others, have emphasized the observation that the danger of a fatality rises rapidly with advancing age and is materially higher in patients beyond the age of fifty years than it is in younger individuals. Blackford and Williams recently reviewed a series of 116 cases in which death occurred from massive hemorrhage from either a duodenal or a gastric ulcer: the persons were more than forty-five years of age in 97 per cent of the cases in this series, and in 78 per cent of the cases death followed the initial and only hemorrhage. Recovery from a massive hemorrhage offers no assurance that subsequent bleeding from a duodenal ulcer will not occur. Means has directed attention to the observation that, as the mortality from massive hemorrhage increases with age so, too, does it increase with each recurrence. This all leads to the question, "How much and how often shall one bleed from an ulcer before serious consideration is given to surgical intervention?" A definite policy of management of massive hemorrhage from a peptic ulcer which has eliminated uncertainty and indecision consists of: (1) Transfusion of blood for the purpose of restoring blood volume; (2) consideration rarely of surgical intervention during the hemorrhage in patients under fifty years of age; (3) surgical intervention as soon as the patient's general condition will permit an operation with reasonable safety when massive hemorrhage has occurred two or more times in persons under fifty years of age; (4) operation is advised for patients more than fifty years of age, when no improvement occurs within from twelve to twenty-four hours as the result of repeated or continuous transfusion of blood, and (5) fate is not tempted again, but operation is advised in patients more than fifty years of age who have recovered from a massive hemorrhage. During the last three years I have performed partial gastrectomy for massive hemorrhage from a duodenal ulcer in twenty-seven cases, with one death. There have been twenty-two consecutive cases without a death. The youngest patient in whom partial gastrectomy was performed for massive hemorrhage was twenty years of age; the oldest was seventy-five years of age; the average age, 47.8 years.

In general, the mortality rate following surgical intervention for massive hemorrhage from peptic ulcer has been greatly in excess of that when the

* Read before the Section on General Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

treatment of massive hemorrhage has been entirely by nonsurgical measures, because it has been the mortality of surgical procedures instituted late in the cases of medical failure, and not the mortality rate of early surgical treatment in all cases of bleeding ulcer.

TYPE OF SURGICAL PROCEDURE

As the limitation of indications for surgical intervention in duodenal ulcer has during recent years been more closely drawn, so have the purposes of an operation been more often most adequately served through excision of the ulcer. It is true that an ulcer in the anterior wall of the duodenum can be excised by one or another of the relatively simple procedures, and that an ulcer in the posterior wall of the duodenum can often be removed through transduodenal and other conservative methods. However, the incidence of recurrence of ulcer has been high following such operations. It has by this time become quite apparent that local excision alone provides little assurance against recurrence of ulcer, and it has likewise been observed that the indirect conservative operations combined with excision of the ulcer, and devised for the purpose of diluting and neutralizing gastric acidity and gastric secretion by duodenal or jejunal content, have too frequently been followed by anastomotic or jejunal ulcer. Inconstant and insufficient neutralization and dilution of gastric secretion have contributed to the failure of conservative operations to adequately control gastric acidity, and provide reasonable if not maximum assurance against anastomotic or jejunal ulcer. The frequency with which anastomotic and jejunal ulcer have followed gastro-enterostomy and other conservative operations has justified quantitative reduction of gastric acidity and gastric secretion in an effort to obviate such new postoperative ulcers. Through partial gastrectomy a method is provided for the control of gastric acidity by quantitative reduction and neutralization and dilution. It may be stated, then, that the purposes of gastric resection in certain cases of duodenal ulcer are either excision of the ulcer or quantitative reduction of gastric acidity or both. In performing partial gastrectomy both objectives usually may be served.

Experience has by this time pretty well established the idea that in the bleeding duodenal ulcer, in the penetrating ulcer, and in the ulcer which has recurred following the simple closure of an acute perforation, the purposes of surgical intervention are usually best served through performing partial gastrectomy. It may be stated that usually recurring hemorrhage from an ulcer can be permanently controlled only through excision of the bleeding lesion. The futility of employing any surgical procedure for the arrest of bleeding, which does not include excision of the ulcer, has been observed so often that one may justifiably take the position that unless the surgeon is competent and is prepared to excise the ulcer by one method or another surgical intervention should not be contemplated. Experience has proved that usually a bleeding ulcer can be excised most advantageously by performing a partial gastrectomy. Many bleeding duodenal ulcers are situated on the posterior wall of the duodenum, and adequate access to this area, to facilitate excision of the ulcer-bearing portion of the duodenum, is often gained only after transecting the stomach at some level proximal to the pylorus.

The penetrating ulcer of the duodenum, particularly the ulcer in the posterior wall in which protective perforation has occurred with penetration of the pancreas, presents technical problems in its excision, the satisfactory solution of which in many instances may be found only through transection of the stomach with removal of the distal portion thereof, and the first portion of the duodenum to a level just below the ulcer. Similar problems are not infrequently encountered when recurrence of an ulcer following simple closure of an acute perforation requires subsequent surgical consideration, and the solution of these is likewise at times to be found only through the removal of a part of the stomach. It is not to be inferred that when partial gastrectomy is performed for duodenal ulcer the ulcer-bearing area of the duodenum should always be included in the resection. There are instances in which a resection limited distally by the pylorus will suffice, and in certain other instances the added hazard of excising a penetrating ulcer in the presence of extensive inflammatory reaction is not justified. However, failure to include a bleeding duodenal ulcer within the scope of the resection constitutes a serious compromise of the primary purpose of an operation for this particular complication.

Failure to control gastric acidity adequately through dilution and neutralization alone by the conservative operations has provided the impetus for quantitative reduction of gastric acidity and gastric secretion through removal of acid-secreting gastric mucosa by partial gastrectomy. Through partial gastrectomy acid-secreting gastric mucosa in varying amounts may be removed and through restoration of gastro-intestinal continuity by gastrojejunal anastomosis the jejunal content becomes available for its additional neutralizing and diluent effect upon gastric acids.

THE EXTENT OF GASTRIC RESECTION

The magnitude of partial gastrectomy for duodenal ulcer, as pertains to the amount of stomach that it is advisable to remove, is variable and is subject to many factors. The terms partial gastrectomy, subtotal gastrectomy and gastric resection imply removal of a circumferential portion of the stomach without designation of the amount of stomach which is removed in the resection. Not until qualifying terms are universally adopted to designate the amount of stomach that is removed in the operation of partial gastrectomy can comparative results be determined in terms of the extent of the resection. I have suggested that

removal of the pyloric half of the stomach be designated as hemigastrectomy, and that the various other magnitudes of gastric resection be designated in terms of thirds, quarters, fifths, et cetera. Friedell has used linear measurement to determine the extent of the resection. Wangensteen has designated the amount of stomach removed in terms of the number of square centimeters of serosal surface.

In the quantitative reduction of gastric acidity and gastric secretion by gastric resection two important questions arise: (1) How much shall the gastric acidity and gastric secretion be quantitatively reduced? (2) How much of the stomach shall be removed to provide the desired reductions? These questions have to do with the problem of recurrent ulcer following partial gastrectomy.

There are those whose enthusiasm for quantitative reduction of gastric acidity has led them to extend the operation of gastric resection for duodenal ulcer to the point of establishing constant achlorhydria to histamine stimulation. Wangensteen has said that operations which fail to afford real promise of achlorhydria leave too much to chance, and hold out too great a risk of gastrojejunal or recurring ulcer to stamp them as satisfactory operations to be invoked frequently for the surgical relief of ulcer. He likewise has said that to procure achlorhydria with a high degree of regularity, it is necessary to sacrifice 66 to 80 per cent of the gastric tissue.

That gastric acidity bears a direct relationship to recurrent ulcer is generally accepted, but that reasonable or maximum assurance against a postoperative anastomotic or jejunal ulcer is dependent upon complete abolishment of free hydrochloric acid in the stomach is hardly in full accordance with clinical data at hand. One should remain mindful of the fact that many patients have obtained permanent cure of duodenal ulcer following gastro-enterostomy, and certain other conservative operations through which achlorhydria is seldom if ever established. Also, that even though anastomotic and jejunal ulcers have developed in a small percentage of cases in which gastric resection has been performed, there is much to suggest that such new ulcers have developed for the most part in those cases in which pylorectomy or resection limited to the pyloric third or quarter of the stomach had been carried out, with little if any quantitative reduction of gastric acidity and gastric secretion.

Whatever the mechanism may be by which hydrochloric acid is formed, it is generally agreed that the parietal cells in the gastric glands are largely concerned, and that the degree of gastric acidity is dependent upon them. They are present in all of the gastric glands, but are most numerous in the glands of the body and fundus of the stomach. If one may presume that the preoperative degree of acidity can be reduced proportionately to the amount of parietal cell content of the stomach which is removed by gastric resection, it remains to decide upon what degree of postoperative acidity one wishes to attain in accordance with one's own ideas pertaining to the relationship of the degree of gastric acidity to recurrent gastrojejunal or jejunal ulcer, and thereby determine the extent of the gastric resection. If one subscribes to the idea that achlorhydria to histamine stimulation is necessary to provide maximum assurance against recurrent ulcer, and that there are no physiologic or other deterrents to a constant achlorhydria, he will of necessity sacrifice 65 to 80 per cent of the gastric mucosa. To sacrifice that amount of gastric structure amounts to practically total loss of gastric function, and from the functional standpoint is equivalent to total gastrectomy. On the other hand, if one can subscribe to the idea that gastric resection of a lesser extent, with preservation of a low degree of gastric acidity, will provide reasonable assurance against recurrent anastomotic or jejunal ulcer, then satisfactory gastric function can be maintained, and the sequelae of constant achlorhydria can be obviated. Or, to state the matter otherwise, considerable data have accumulated which strongly support the idea that removal of half of the stomach—hemigastrectomy—usually ensures a reduced gastric acidity by quantitative reduction, and dilution and neutralization, through gastrojejunal anastomosis, preserves satisfactory gastric function, and provides reasonable assurance against a subsequent anastomotic or jejunal ulcer. In my own work I have observed anastomotic or jejunal ulcer on several occasions in patients in whom I had previously performed a limited gastric resection. On the other hand I have not observed what might be clinically or roentgenologically suspected as a recurrent anastomotic or jejunal ulcer, in a case in which the extent of the gastric resection for duodenal ulcer had been designated as hemigastrectomy, whether or not a constant postoperative achlorhydria had been established thereby.

The degree of gastric acidity is extremely variable, and only through repeated determinations may one approximate the probable average acid curve. From the practical viewpoint false values are too often obtained upon which the extent of the resection may be predicated, and upon which the postoperative results are determined in terms of the degree to which the acids have been quantitatively reduced when the preoperative and the postoperative curves of the gastric acids are plotted after histamine stimulation. One should remain mindful of the fact that reduction of gastric acidity, following gastric resection, is brought about not through the removal of acid-secreting gastric mucosa alone, but through dilution and neutralization by jejunal content as well; and since diluent and neutralizing material is thereby made available, the quantitative reduction of gastric acidity may be conservative rather than radical to achieve the approximate desired postoperative acid values.

It is my opinion that postoperative achlorhydria is not only unnecessary to afford, if not the maxi-

mal, at least reasonable assurance against recurrent ulcer, but that postoperative achlorhydria is undesirable. My own experience with gastric resection in certain cases of duodenal ulcer has provided me with data which strongly support the thesis that postoperative reduction to approximately one-half of the preoperative degree of acidity provides a reasonable degree of assurance that an anastomotic or jejunal ulcer is a remote possibility. In accordance with this line of reasoning it has been my policy for the most part to confine the magnitude or extent of gastric resection in duodenal ulcer to the pyloric half of the stomach, including the lesser curvature angle of the stomach (hemigastrectomy) and usually the ulcer-bearing portion of the duodenum, resorting to slightly higher resection only in those cases in which the preoperative total acids exceed 100.

It is conceded, even though that has as yet not been my experience, that one may occasionally undershoot the target when performing hemigastrectomy for duodenal ulcer, and that an anastomotic or jejunal ulcer may follow resection of that extent. However, to aim at removal of 75 to 80 per cent of the gastric structure with the sacrifice of most, if not all of gastric function in all cases, for the purpose of obviating the development of an occasional anastomotic or jejunal ulcer, hardly seems justified. Such an approach to the problem of the cure of duodenal ulcer is quite analagous to the questionable thesis of total thyroidectomy in the treatment of hyperthyroidism, whereby the clinical manifestations and problems of hyperthyroidism are exchanged for those of myxedema.

The results of gastric resection in duodenal ulcer must be analyzed at their full value, not only as they pertain to the curability of the ulcer but in terms of nutritional changes and deficiency states as well and in terms of the physiological and biochemical processes in the organism as a whole, as they are influenced by the magnitude or the extent of the gastric resection. The evidence is far from conclusive that the curability of benign duodenal ulcer is dependent upon radical three-quarters or four-fifths gastric resection, and that in order that cure of the ulcer may be achieved, the sequelae of major if not total loss of gastric function must be accepted.

The basic principles upon which the philosophy of gastric resection in certain cases of duodenal ulcer is founded are today generally accepted as entirely sound, and partial gastrectomy has attained a status in the surgical treatment of this disease which may be sustained and enhanced by the judicious selection of cases wherein it is justifiably applicable in accordance with its objectives. Through the future universal adoption of a method by which the extent of gastric resection may be designated in terms of the amount of stomach removed, an opportunity may be provided for analysis of the advantages and disadvantages of the various magnitudes and extents of gastric resection, not only as pertains to the curability of duodenal ulcer but as pertains to the organism as a whole.

727 West Seventh Street.

EMERGENCY TRANSFUSIONS: SUGGESTIONS FOR HOSPITALS, CLINICS, AND LABORATORIES

JOHN R. UPTON, M. D.
San Francisco

EVERY day urgent requests for information pour into the Irwin Memorial Blood Bank of the San Francisco County Medical Society from all parts of the Far West. We are taking this opportunity to answer the questions most frequently asked. These may be condensed into four parts:

Question 1.—How can we best protect the lives of disaster patients when they need an emergency blood transfusion?

Question 2.—Can we obtain blood and plasma from your Bank if we build up a reserve?

Question 3.—How can we doctors in towns removed from San Francisco help in the Red Cross Procurement project?

Question 4.—Can we call on your Bank for blood if we are faced with an emergency problem in our community even though we have not built up a credit?

Before we answer these specific questions let us say that this is a time for clarity of thought and logical planning. Make available and use every resource that is at hand instead of waiting for or depending on larger or more completely stocked centers for transfusion fluids. The following suggestions will amplify and clarify our statement.

Answer 1.—We advise that all professional, technical and other personnel of hospitals, clinics, and laboratories have immediate typing and serology tests performed so that each such center, no matter how small, may form a blood bank nucleus for immediate emergency use in case an unforeseen accident occurs in their center. Particularly guard your type 4's(O), know where they can be reached night and day. Eventually every adult in the community should be typed and each adult must carry his identification type card with him. Never forget that the finest container made for blood is the human body—this fact must be reemphasized again and again in order to counteract a certain uneasiness among some groups. Type as many people as you possibly can, card index your donors and when that is accomplished you have a potential blood bank available for instant use.

Answer 2.—At the present time we are operating an non-profit Blood Bank supplying (a) whole blood to the Hospitals of the San Francisco Bay area on call throughout the 24 hours. (b) The Irwin Memorial Blood Bank of the S.F.C.M.A. was appointed the Red Cross Procurement Center for Northern California. This appointment entails drawing blood from volunteer donors and such blood will be sent for processing to the Cutter Laboratory in Berkeley.

It is certainly possible for you to obtain whole blood at any time from our Bank on payment of

our small maintenance fee, plus a donor to replace the blood that was sent out. Hospitals outside the confines of San Francisco must absorb the extra delivery fee. The Greyhound Bus service has been quite prompt in expediting deliveries to the Peninsular Hospitals.

Answer 3.—Please read the announcement in the January C. M. A. Suffice it to say there will be an opportunity for every medical man to assist. As a matter of fact the entire plan devolves on your full cooperation. It will not fail.

Answer 4.—The Blood Bank was created particularly to care for those who need blood, be it an emergency or otherwise. However, taking a theoretical problem. Hospital X has built up a reserve of 100 units. Hospital X asks for 75 units immediately to take care of some disaster, but Hospitals A and B likewise have a reserve and wish to draw on that reserve to the limit. Our policy in this case would be to send as much blood as possible to all three hospitals but without emptying the bank completely.

SUMMARY

In closing let us emphasize certain points: Go over your bleeding and donor sets to make sure you have sufficient rubber tubing and needles—always cleanse and sharpen the needles, reassemble and sterilize after use so that you always have sets immediately available. Check your flasks, funnels, syringes etc., and stock of anticoagulant, if short, replenish immediately.

Type and card index *all* personnel paying particular attention to Type (O). The cost for this service should not be borne entirely by physicans.

If possible acquire several flasks of liquid serum. (Cutter) We suggest serum, for plasma in the liquid state develops fine granular precipitates and fibrin veils; these are not, however, of any concern and only require filtering out. If not too far removed from San Francisco build up a reserve of blood donors so that you can call on us for whole blood. When the national emergency has past we will undoubtedly make available frozen plasma and dried plasma.

We invite your questions. If in San Francisco please pay our Blood Bank a visit—you are always welcome.

2180 Washington Street

NEWER PHYSIOLOGY OF THE BILIARY TRACT AND ITS APPLICATION TO BILIARY TRACT DISEASE*

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THE gallbladder and extrahepatic bile ducts rank high among the causes of gastro-intestinal symptoms for which patients seek medical aid. A better appreciation of the physiological processes involved may help us to understand some of their abnormal manifestations or pathological conditions. It is my purpose, first, to review briefly the fundamental functions and activities of the biliary tract, then to discuss how the distention of the biliary tract may reflexly affect other organs or viscera, and to cover, in summary, the anatomy, physiology and pharmacology of the sphincter of Oddi as well as the physiology of bile and some of its practical features.

GALLBLADDER FUNCTIONS

The gallbladder possesses two general functions: it is a bile reservoir and a pressure regulatory mechanism. In species which secrete relatively small amounts of bile daily, a gallbladder is present to store and concentrate the bile until after the next meal, when the response of the mucosa of the upper part of the small intestine to fats and acid, produced by the liberation of the hormone cholecystokinin, causes the gallbladder to contract and discharge its contents into the duodenum.[1] The flow of this concentrated bile, because of the bile salts it contains, acts as a trigger mechanism and causes a choleretic or increased secretory effect on the liver, which in turn leads freshly-secreted bile to enter directly into the duodenum during the digestion of the meal.

The importance of the gallbladder as a regulatory mechanism has been stressed many times by Ivy[2] and his coworkers. The secretory pressure, or the pressure above which the liver will not secrete bile, is 30 cm. of bile pressure. The evacuatory power of the gallbladder is no greater than from 20 to 30 cm., while the average resistance of the sphincter of Oddi is from 9 to 25 cm. The resistance of this sphincter mechanism may be elevated temporarily to as high as 75 cm, in which case the bile secreted by the liver would slowly fill the gallbladder, thereby preventing back-pressure on the hepatic cells. In order to keep the pressure in equilibrium, when the gallbladder contracts, the sphincter relaxes. Thus an explanation of the three types of biliary dyskinesia is tenable. 1. The hypermotile type is characterized by increased motility of the gallbladder with rapid emptying, which may produce colicky pain. 2. In the hypertonic type, the gallbladder attempts to contract against a spastic sphincter. 3. Atonic distention of the gallbladder causes an aching pain over that region. A low fat diet and alkalies should be used in the first type, and a high fat diet, plus acid foods, in the third, while methods used to relieve spasm of the sphincter should be tried in the second, as well as the treatment of colonic stasis which might reflexly affect the sphincter. Many of the surgical failures in disease of the gallbladder fall into the group of dyskinesias, accounting in part for the poorer results following the removal of the stoneless gallbladder. Surgical or pathological cholecystectomy usually is followed by changes in the resistance of the sphincter and dilatation of the extrahepatic bile ducts, suggesting a further control of the gallbladder over the regulation of

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† For additional comment on Irwin Blood Bank, see page 20.

pressure. It has been shown by Mann and Bollman [5] that the gallbladder acts as a buffer in delaying the onset of jaundice after obstruction of the common duct, thereby temporarily lowering the intraductal pressure.

The activities of the gallbladder, similar to those of the small intestine, are absorption, secretion and contraction. The hepatic bile is concentrated from 4 to 10 times, mainly by the absorption of water. Normally, bile salts, cholesterol, bile pigment and calcium are concentrated in the gallbladder. When stasis occurs in this organ by reason of intermittent obstruction of the cystic duct, the bile salts, which are the solvents of cholesterol, may be absorbed, thereby altering the normal bile salt-cholesterol ratio and favoring the precipitation of cholesterol calculi. An inflamed gallbladder is able to absorb bile salts and calcium, and permits exudation of serum protein, blood and chlorides into the lumen [4]. In prolonged obstruction of the cystic duct, all the constituents of bile eventually are absorbed and replaced by mucus. The gallbladder has the ability to secrete about 20 to 30 cc. of mucus daily, which continues in the face of obstruction of the cystic duct and forms the so-called white bile.

The liberation of the hormone cholecystokinin from the upper part of the small intestine, in response to a fatty meal, produces the greatest excitant to contraction of the gallbladder. All fats, especially egg yolk and cream, as well as acids, are effective in stimulating the production of this hormone. If the diet is completely free of fats, therefore, contraction may not take place and stasis results. Some fat is usually tolerated; it is desirable to administer an amount just below that which produces pain. Because fats produce contraction, they should be withheld in acute cholecystitis. Cole [6] believes that there may be a physiological, sphincter-like action at the junction of the neck of the gallbladder with the cystic duct, which may cause a partial obstruction to the forceful contraction of the gallbladder and result in colicky pain. The bile ducts conduct the bile into the duodenum from the liver and gallbladder. The sphincter of Oddi, by its contractions, permits the gallbladder to fill, and by its valvules prevents ascending regurgitation or infection from the duodenum.

DISTENTION OF THE GALLBLADDER OR BILE DUCTS

Sudden distention of the gallbladder or bile ducts may have various effects:

1. True visceral pain may occur, brought about by sudden changes in tension or tone of the musculature of the biliary tract. This is interpreted by the patient as diffuse pain in the right upper quadrant or deep epigastrium [6].

2. A viscero-somatic reflex may be set up, causing radiation to the back, right subscapular or interscapular region [7]. Pain in the shoulder seldom occurs from distention of the tract alone, but usually signifies irritation of the peritoneal surface of the diaphragm by fluids or some inflammatory product.

3. Nausea and vomiting are caused by reflex pylorospasm and contraction of the pyloric antrum.

4. Reflex inspiratory distress is present in about 30 per cent of patients, and is caused by fixation of the right half of the diaphragm [8]. This is a common symptom in patients with sudden obstruction of the cystic duct. In elderly persons with acute cholecystitis or sudden colic of the cystic duct, the diagnosis of basal pneumonia may be erroneously made. Occasionally, because of this immobility of the diaphragm, a true pneumonic process may develop which may be overlooked.

5. In animals and man cardiac arrhythmias have been produced by distention of the biliary tract [9]. This is more likely to occur when the ducts, rather than the gallbladder, are distended. In elderly patients whose hearts may be sensitized by myocardial damage, auricular fibrillation may occur. This happens not merely because of infection, but because of sudden distention of the gallbladder or bile ducts.

6. Gastric flatulence may occur because of reflex loss of gastric tone and the aspiration or swallowing of air. This has been observed in animals.

7. Pseudo-angina or cardiac pain, associated with symptoms from the biliary tract, usually means that disease is present both in the coronary arteries and the biliary tract. The radiation of the pain of coronary occlusion to the right upper quadrant has been sufficiently emphasized in the literature so that the diagnosis of acute cholecystitis is seldom erroneously made.

SPHINCTER OF ODDI

It has been shown that there are three separate muscular structures which affect the resistance of the sphincter of Oddi or choledochoduodenal mechanism, thereby controlling the flow of bile into the duodenum. Schwegler and Boyden [10] showed that an independent group of annular fibers, the sphincter choledochus, surrounds the intramural portion of the common duct and ampulla. This structure is well developed, and has the ability to retain independently a column of bile [11]. Its static contraction causes the gallbladder to fill with bile. Hypertonic contraction of this muscular mechanism may result in dyskinesia and simulate organic cholecystic disease [12]. Two longitudinal muscle bands, which facilitate the ejaculation of bile into the duodenum, lie between the pancreatic and common bile ducts.

2. In about 70 per cent of persons, a true ampulla is present, while in the remainder, the ducts enter the duodenum without joining. Surrounding the ampulla is the "sphincter ampullae" which, when spastic, may permit bile to enter the pancreatic duct or pancreatic secretion to enter the biliary tract. It has been estimated by Doubilet and Colp [13] through anatomical studies that this sphincter is well enough developed to cause this regurgitation of secretions in only 16 per cent of cases.

3. Because of its peristaltic activity, the duodenal musculature also may act independently in altering the resistance of the choledochoduodenal mechanism [14]. A relationship may exist between the pancreatic and common bile ducts at the ampulla so that the two may be converted into a continuous channel by obstruction at the papilla [15]. This obstruction might be caused either by calculus, inflammation, or spasm of the sphincter ampullae. Varying intraductal pressure is probably the factor which determines the direction of the flow. If pancreatic secretions enter the gallbladder, acute cholecystitis may take place [16]. Physiological disturbances of the sphincter of Oddi are an important factor in the pathogenesis of certain types of acute pancreatitis, gallbladder disease, post-cholecystectomy syndrome, biliary dyskinesia and some forms of transient jaundice.

The pharmacological activity of certain drugs, and the responses of the sphincter to foods, have been worked out by several investigators. It has been shown that the fatty meal, cholecystokinin, amyl nitrite, nitroglycerine, magnesium sulphate, histamine, theophylline and trasentin cause a decrease in the resistance of the sphincter mechanism. Morphine, pantopon, dilaudid, codeine and hydrochloric acid cause an increase in resistance. A carbohydrate meal, alcohol, atropine, benzedrine, calcium ergatomine, hyacine, papaverine, phenobarbital, physostigmine, pilocarpine, pituitary extract and prostigmine have no effect on the sphincter mechanism in man. These facts give us the basis for the work of Best and Hickens [17] and Walters and his group [18] on therapeutic measures to affect the sphincter of Oddi. These activities are certainly of value in the treatment of the small stone overlooked or remaining in the common duct, as shown by cholangiography after operation. By the administration of nitroglycerine, magnesium sulphate or fats (particularly olive oil) to relax the sphincter, and bile salts to stimulate the flow of bile from above, an attempt to wash out the stone has proved of value in many cases. The use of morphine, in overcoming the pain of spasms of the sphincter, is effective only through its sedative action on the central nervous system, as its local action is one of contraction. The action of amyl nitrite is very fleeting, lasting only 10 or 15 minutes, while that of nitroglycerine may last as long as two or three hours.

Ivy and Goldman [19] showed, in 90 per cent of their animal experiments, that stimulation of the nerves supplying the colon produced an increased resistance of the choledochoduodenal mechanism amounting to from 5 to 21 cm of saline solution. This increased resistance outlasted the period of stimulation, in most of the tests, and was associated with increased tonicity of the duodenal musculature. This presents evidence that the resistance of the sphincter may be effective reflexly. It has been shown by Gerdes and Boyden [20] and Mann and Higgins [21] that, during the later part of pregnancy, there is a delayed evacuation of the gallbladder in response to a fat meal due to an increased resistance of the sphincter. This is brought about either by reflex activity or the action of sex hormones on the sphincter itself.

BILE SALTS

The three important constituents of bile are: bile salts, bile pigments and cholesterol. Bile is essential for life; animals with external biliary fistulae die within 2 or 3 months, but if they are fed bile, they may live from 6 to 9 months, then succumbing to infection. Cholegogues stimulate the evacuation of the gallbladder and increase the flow of bile into the intestine, while choleretics produce an increased flow of bile from the liver. The important bile salts found in human bile are chiefly cholic acid and deoxycholic acid, which exist in about equal proportions and are conjugated with glycine or taurine. It has been shown that the only toxic substances in bile are the bile salts.[22] The toxicity of these salts parallel their activity in lowering the surface tension of fats [23]. Deoxycholic acid, which is potent as far as the intestinal absorption of fats is concerned, is the most toxic. Dehydrocholic acid (decholin), which is a synthetically oxidized preparation of cholic acid, has the least effect in the intestinal tract and the lowest toxicity, but a marked effect on increasing the volume of the flow of bile from the liver (from 100 to 200 per cent). It should be used, therefore, only to stimulate the flow of bile. The output of bile by the liver is rather constant under unchanging conditions. A high protein diet increases the amount of bile secreted by the liver, a high fat diet causes a slight increase, while carbohydrate is not effective. The bile salts absorbed by the intestinal tract are carried to the liver and reexcreted. This is known as the enterohepatic circulation of bile salts, and in each circuit there is a loss or destruction of 10 per cent of bile salts, which is replaced by endogenous or exogenous protein in the diet.

THE FUNCTIONS OF BILE SALTS

1. They assist in the emulsification and absorption of fats and augment the action of pancreatic lipase [24].

2. They promote the formation of bile. They raise the volume output and the total output of cholesterol, but have very little or no effect on the output of pigment in the normal animal. The administration of natural bile salts thins the bile by decreasing its viscosity and increasing its total water content.

3. Bile salts keep cholesterol and fatty-acids in solution in the gallbladder, thereby preventing precipitation and the formation of stones.

4. They assist in the absorption of iron and calcuim, and are necessary to the absorption of vitamins A, D, E and K. Desoxycholic acid has been shown by Greaves and Schmidt [25] to be the acid to use in obtaining absorption of these vitamins.

5. Bile salts stimulate intestinal motility and thereby act as a natural laxative. Johnston, Irvin and Walton [26] suggested that choline is present in

sufficient quantities in bile to account for this effect on the intestine. Goldman and Ivy[7] showed, experimentally, that artificially-produced conditions in the dog, comparable to constipation, namely distention of the colon or stimulation of its splanchnic nerve supply, was associated with and followed by an inhibition of 50 per cent in the secretion of bile by the liver. This is prevented by administering bile salts and is a further support for their use as a cathartic.

6. They are said to detoxify bacterial toxins and hence prevent putrification.

7. It is claimed that their secretion stimulates the storage of glycogen in the liver. There is contrary evidence, however, which suggests that when bile salts are being secreted, hepatic glycogen is diminished.

8. Although bile salts increase the excretion of cholesterol by the liver, as well as the excretion of bile salts, they favorably influence the bile salt-cholesterol ratio, provided the liver is not damaged. It has been shown by Ravdin and other workers that, when obstruction of the common bile duct is relieved, the first bile which is obtained contains pigment, but usually bile salts in very low concentration or none at all. In other words, the liver may excrete pigment, but is not able to secrete bile salts. Bile salts may not reappear in the bile until from five days to three weeks after operation, depending on the degree of damage to the liver. This has some practical significance, in that it offers evidence opposing the custom of returning the patient's own bile by gastric tube; because this bile often contains only pigment and a low concentration of other elements, with little or no bile salts. Instead, a preparation of natural bile salts should be given orally to substitute its functions in the intestinal tract. It is wiser to give the patient bile salts, rather than a preparation of whole bile, because the pigment in the whole bile will color and mask the test for pigment, while bile salts are colorless and will not affect this determination. Patients with external biliary fistulae, and loss of bile from the body, quickly develop pancreatic asthenia, anorexia, loss of weight, fatty stools, constipation, anemia and bleeding tendencies, and dehydration. By administering a naturally-conjugated bile salt, the deleterious effects of the loss of bile from the intestine will be overcome, and the general condition of the patient will be improved. The oxidized bile salts, when given intravenously, are less toxic than the natural unoxidized bile salts. Since bile salts are readily absorbed from the intestine, however, there is little use for intravenous therapy. When one wishes merely to increase the flow of bile, thin the bile, possibly flush out the gallbladder or flush out any inspisated material, blood clot, debris, or sand from the common bile duct, the oxidized bile acids—as decholin, procholon or ketochol—should be used, because they are the least toxic. If a bile preparation is to be used for the intestinal action, these oxidized bile salts should not be used but, instead, natural-appearing bile salts, preferably conjugated, preparations of whole bile or deoxycholic acid should be used. For absorption of fat-soluble vitamins, the deoxycholic acid is preferable. Bile salts are toxic and should not be used indiscriminately.

INDICATIONS FOR THE USE OF BILE SALTS

1. The absence of bile salts from the intestine. In such cases preparations of bile salts should be administered to improve the digestion and absorption of fats and fat-soluble vitamins.

2. In obstructive jaundice, bile salt therapy is indicated for the absorption particularly of Vitamin K, the anti-hemorrhagic vitamin. Since bile salts are toxic, there is not sufficient evidence, as yet, to suggest that their administration may not be harmful in the presence of damage to the liver, either long-standing jaundice or cirrhosis.

3. To thin the bile and flush the gallbladder or bile ducts. The liver function in these cases must be sufficient to respond to this choleretic stimulus. By increasing the volume flow of bile by the liver, there may be a tendency to prevent ascending infection, in the same way that increasing the urinary output flushes out the lower urinary tract. Stimuli from the colon or its nerve supply cause an inhibition in the secretion of bile by the liver, as well as an increased resistance of the sphincter of Oddi. The administration of bile salts would promote peristaltic activity and help to overcome these effects.

4. A number of clinical observers have inferred bile salt therapy to be beneficial to the liver, especially after the relief of obstruction of the common duct. If the liver is damaged, the administration of bile salts cannot be expected to improve its function. The toxic effects of bile salts in such cases may be deleterious, and caution should be exercised in their use. In such conditions, they should be administered only for particular reasons of intestinal absorption.

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PSYCHIATRIC PROBLEMS IN PRIVATE PRACTICE: THEIR MANAGEMENT*

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STATISTICS as to the incidence of nervous and mental disease in medical practice are hard to obtain. Estimates run as high as seventy or eighty per cent. We do know that approximately forty-one per cent of all hospital beds in this country are occupied by mental and nervous diseases. It is recognized that a great many nervous and mental cases which should be hospitalized escape such care and, therefore, are not included in the figures just quoted. Obviously, all of us, whatever our specialty, come in contact with neuropsychiatric problems. The internist is especially exposed and susceptible.

Internists rightfully occupy the first line of offence in attacking neuropsychiatric problems, for their satisfactory handling depends as much on a thorough physical study as on an adequate personality analysis. Thirty years ago, approximately ten per cent of the major psychoses were recognized as having an organic basis. Now the percentage has risen to between thirty and forty per cent. It seems altogether probable that the remaining sixty per cent, now classified as functional, will eventually join the organic group. In short, all nervous and mental cases should be studied carefully from the standpoint of internal medicine, either by the internist before reference, by the psychiatrist whose training should be adequate, or by the two men working together. Certain points in the technique of this study are perhaps more familiar to the psychiatrist than to the internist. It is to these points I wish to direct your attention with the hope that they may be of interest, and perhaps of help, to some of this combined group.

The psychoneurotics, like the poor, are always with us and their number is legion. In fact, the late Joseph Choate's famous remark, that the difficulty of the problem of the feeble-minded was, that there were so many of us, might also apply to the problem we are discussing. Personally, I am grateful to one internist for expressing his opinion of a neuropsychiatrist who knocked wood. His somewhat expressive remarks resulted in a complete cure, for I have never knocked wood since the time he was kind enough to call the matter to my attention.

EARLY DIAGNOSIS

In dealing with psychoneurotics, an early diagnosis is essential. Such a diagnosis can be made only by the process of elimination. Therefore, these patients are entitled to as complete a survey as the judgment of the examiner deems necessary to rule out organic disease. Unnecessary examinations, and useless repetition of tests, in the hands of several different men, are likely to do more harm than good. On completion of the study, it should be recognized that the explanation of results obtained, and of the conclusions to be drawn from them, may be of greater therapeutic value to the patient than the actual findings.

INTERPRETATION OF FINDINGS

The interpretation of positive physical findings for which definite medical and surgical treatment are indicated, and an explanation of the probable results to be expected from such treatment, is of great therapeutic value. Emphasis on negative findings is also of great importance, and may even result in a symptomatic cure of the case. On the other hand, lack of thoroughness or interest, any evidence of doubt in the mind of the examiner, is readily imparted to the patient and promptly nullifies any good accomplished by the examination. Careless or partial presentation of the findings is unquestionably detrimental to the patient. Be complete and definite. The patient needs and will not be satisfied until he receives an adequate explanation of his symptoms. To be told he hasn't this or that helps, but he also needs to understand the reason for the symptoms he does have. Don't forget the definite scientific work that has been

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done on conditioned reflexes. If a dog can be conditioned to react the same physiologically to the prick of a needle as to an injection of morphine, certainly man is constantly developing conditioned reflexes. Realization of this is important to the physician and to the patient. The day of "you imagine your symptoms, forget them," is definitely gone.

Suggestibility, which you will all remember as a tendency to accept something as true without adequate reason for so doing, is present in us all, and is exaggerated in the psychoneurotic. This tendency should be made use of constructively. No better time will ever present itself than when a complete study has just been finished. It is a matter of record that a definite percentage of cases in private practice, as well as among the neuroses treated during the last war, have gone from total incapacity to complete recovery as the result of one interview.

Many of the cases you rightly classify, as psychoneurotics, will also have minor physical disorders which need and are capable of correction. Furthermore, correction of these physical disorders may occasionally give the patient a sufficient start to enable him to overcome his purely nervous symptoms. Good judgment is required to recognize the exact time when the borderline case should be turned over to the neuropsychiatrist, for the good of the patient as well as the good reputation of the internist.

There may come a time, in medical and surgical illnesses, when the physician or surgeon recognizes that the objective findings do not satisfactorily explain the severity of symptoms present or their lack of improvement. Under such conditions, remember you are dealing with a person as well as a disease. Emotional problems may account for the situation.

Personality problems may also express themselves on the surface as purely somatic disorders. These situations should be recognized at the earliest possible stage and treated for what they are. Either the internist should be able and willing to give the time for a frank discussion, followed by suggestions and advice; or he should send the patient where he can have this opportunity. Mental catharsis alone is always valuable and often strikingly so.

The major psychoses fall quite frequently to the lot of the internist, especially in their incipiency. Here an early diagnosis, followed promptly by adequate treatment, may literally mean the difference between life and death. The depressions all recover when sufficiently protected during their depressed and, therefore, possibly suicidal period. Early excitements — manic or paretic—may seem only a bit restless or nervous to their families and friends, but may cause great trouble financially and otherwise unless the true nature of their illness is recognized. The internist must be on the alert for these conditions, for he is usually the first man to be called in.

Alcoholism in the mild and severer forms is a problem we all encounter. The internist should be familiar with the theory and practice of the current and, often widely advertised so-called cures, most of which are commercially exploited fakes. Some insight into the psychology of the alcoholic is of great help and readily obtainable. The therapeutic problem presented by these cases is a difficult and withal, a highly specialized one. Unless the internist feels equipped to complete a personality analysis, as well as a physical survey of the patient, he had best refer the patient elsewhere. The percentage of permanent cures in alcoholic addiction is small at best; from physical treatment alone it is practically zero.

LEGAL ASPECTS

In discussing the legal aspects of psychiatric problems, it must be made clear that while the laws are the same throughout the state, methods of procedure may—and it is my understanding do —vary in different localities. I can only speak with authority for Los Angeles and its adjoining counties. It is my hope that some of the discussants of this paper will point out any material difference in local procedure to be found in other parts of the State.

The legal aspects of the treatment of alcoholism should be reasonably familiar to you as internists. The state law used to allow a Superior Court judge, after a hearing, to commit an alcoholic for a period of time up to two years to a state or private institution without the right to demand a jury trial. This procedure did not work out well in actual practice; and about two years ago, the law was changed. The alcoholic is now in the same situation the mental case was before the recent change in the law applying to mental cases. All alcoholics must have a hearing and may demand a jury trial. Any attorney who knows the ropes can obtain the release of an alcoholic, and in the process of so doing will destroy any possible therapeutic advantage already gained. Voluntary commitment is usually unsatisfactory because, as you all probably know from experience, as soon as the alcoholic improves a bit, he becomes an optimist, believes his troubles are all over, and therefore, further treatment unnecessary.

It is also well to remember that the judge may, under the law, vary the procedure if he so chooses. If, as has happened in Los Angeles County, the judge presiding over the Psychopathic Court, refuses to recognize alcoholism as a disease, it follows that he or she may refuse to commit or hold such patients, ruling that they belong in the criminal courts. It is fairly obvious that the therapeutic value of such an attitude is nil, and that psychopathic court procedures should be avoided entirely for the alcoholic under such a set-up. The psychiatrist is usually in touch with the prevailing legal situation and can, therefore, advise intelligently in regard to the wisdom of seeking legal aid from the angle just mentioned, as well as from the medical standpoint.

Certainly, if the alcoholism has progressed to the degree of a psychosis, commitment is not only indicated, but essential. If no psychosis is present, I doubt if legal commitment against the patient's desires has ever been of great value. In my experience, most of the patients so handled come out "rarin' to go," and usually do.

Before dismissing this problem of alcoholism, don't forget that other toxins can produce similar pictures. Bromide, for example, was a frequent offender until greater publicity and the development of a satisfactory technique for blood bromide determinations resulted in widespread recognition of the dangers of its indiscriminate use.

OTHER PHASES

Early recognition of the organic psychoses of old age with the institution of proper care, conserves the health of their families as well as possibly benefitting the patients themselves.

If, in the course of your practice, you encounter an individual who expresses definite ideas of unjust treatment or persecution, and especially if he has in mind certain individuals who are responsible for this, always see that he is put in contact with a neuropsychiatrist—or at least share your problems with the latter. Such cases need expert handling, as they are always potentially dangerous to others.

There should be no truly fundamental differences between the internist's and the psychiatrist's viewpoint. The difference in approach is perhaps due to the fact that the internist tends to be interested primarily in the organic disease present and, secondarily, in the person harboring it. The psychiatrist, on the other hand, is primarily interested in the person and his behavior and, secondarily, in the disease he harbors. Nowadays, all internists practice some psychiatry, and all psychiatrists practice some internal medicine. The internist will be more successful if he prepares himself to practice his psychiatry consciously rather than subconsciously. The psychiatrist in turn should be sufficiently informed to realize his limitations in the practice of internal medicine.

EMERGENCY CASES

Efficient handling of the emergency psychiatric case is obviously founded on an early diagnosis, just as is true in any other field of medicine. Recognized as a psychiatric problem, psychiatric advice should be utilized when available. When such help is not immediately available, the internist must step into the breach, and for such situations the following suggestions are made:

Obtain full information before entering the situation in person. There are a definite percentage of cases where the information obtainable by telephone will be sufficient to determine your advice. If the patient is homicidal or otherwise uncontrollable, and refuses to agree to see a physician, the problem is legal not medical. Some telephone requests for help cover up the real situation and unwittingly you may land in the kind of set-up just described. Withdraw from the firing line as expeditiously as possible, and explain to the interested family or friends that the police should be called. The latter should be ready to deliver the patient to the nearest available psychopathic ward or hospital, where the patient will be held until the necessary steps for his proper legal care can be carried out.

If an acute psychiatric emergency occurs in Los Angeles on a week day between the hours of nine in the morning and five in the afternoon, the next of kin or most interested person must go to the office of the State Lunacy Commission and swear out a Petition to Detain. This petition is then signed by a Superior Court Judge and delivered to the Psychopathic Ward of the Los Angeles County General Hospital, provided the patient is being held there. If the patient is still at home, the petition is served by deputy sheriffs who remove the patient by force, if necessary, to the Psychopathic Ward of the General Hospital. It is usually expected, but not mandatory, that a statement from a physician saying he has examined the patient be presented by the petitioner. The secretary of the Commission may, however, insist on a physician's examination if in doubt as to the situation. If the family cannot afford to pay for such an examination, there is a psychiatrist employed by the court for this purpose, whose fixed fee is paid by the County.

If the acute emergency occurs outside of the office hours of the Commission, then the problem becomes somewhat more difficult. A petition can be obtained and signed at the Psychopathic Ward of the Los Angeles County General Hospital, but then should be signed by a Superior Court Judge. At one time, a judge was available to cover each hour of the twenty-four and each day of the week including holidays. Recently, this has been changed in Los Angeles County, and it is extremely rare for a judge to be available outside of his regular office hours. If the patient is in a private sanitarium, and a Petition to Detain is obtained and signed by the next of kin or most interested party, it is allowable to hold the patient over night, over a week-end or over a legal holiday. If the patient is not in a sanitarium, the police can usually be persuaded to take the patient to the Psychopathic Ward if the petitioner agrees to accompany them, and to sign the petition at the hospital. I have never found the police available to deliver the patient to a private sanitarium even if a petition is produced.

The procedure in less urgent cases is similar, save that the police are not involved. The relative or interested person swears out a petition when the office of the commission is open. After the Petition to Detain is issued, the patient may go voluntarily to the Psychopathic ward or if, as is usual, the patient balks at so doing, the sheriff's office will assume responsibility for his delivery there. In this event, two deputy sheriffs come in a sheriff's car and, after serving the petition on

the patient, will take him by force if necessary to the psychopathic ward.

The patient is held in this ward a varying period of days to permit examination by licensed medical examiners recognized by the state as especially equipped to render such services. After a trial or hearing before a Superior Court Judge, the patient may be discharged as not mentally ill, committed to a state hospital, or paroled under the psychopathic parole department. Should the patient or his attorney demand a jury trial within five days of the hearing, this will be given him. While awaiting such a trial, the patient is usually held in the psychopathic ward. He may, however, be released to his family or to a private sanitarium.

The result of such a jury trial may be accepted as final, or in the event that the authorities believe a dangerous person has been freed by a jury of his peers, they may arrange another trial by swearing out another petition. The procedures, first outlined, always involve the presence of the patient in the psychopathic ward at least for examination, and his appearance before the judge.

About two years ago, a change was made in the law and another procedure is coming into more general use. A patient may be examined by two especially licensed medical examiners who are either members of the old State Lunacy Commission, or newer appointees of the Judge presiding over the psychopathic court, and these physicians then may fill out the Petition to Detain. This paper is then sent to the commission. A psychopathic parole officer visits the patient, and if his or her investigation is satisfactory, approves the Petition to Detain, which then goes to the judge. The judge may parole to a private sanitarium, or commit to a state institution without the patient going to the psychopathic ward or appearing in court. This procedure is greatly appreciated by many families who, without great justification, dread the ordeal of the psychopathic ward for the patient. It is well for the internist to know that such a procedure is possible.

Voluntary commitment is permissible, but is discouraged by state institutional authorities because such commitments rarely stand up for a long enough period to be really helpful to the patient. Furthermore, it is to be noted that the law states that a person signing a voluntary commitment must be mentally competent. This, as I am sure you can realize, leaves a loophole for controversy in court if the state hospital authorities do not agree with the patient as to the wisdom or propriety of his discharge from their institution.

Families or friends of patient's frequently ask the physician, when he has outlined the above procedures, if such steps are really necessary. They suggest the patient be given sedative medication or otherwise restrained, and taken when unconscious or in restraint to a private sanitarium. Is it ever justifiable to thus shanghai a patient without evoking legal aid? The answer is, no. Such a procedure is never justifiable and actually never without danger to the physician advising or taking part in such a course of action. It has been accepted in a Superior Court of California recently, that if any form of restraint is applied to any patient for any appreciable period of time—even though the restraint be removed instantly the patient demands it—the person applying the restraint may be sued for damages, as may the institution where the restraint was applied. This is, of course, provided the full legal requirements have not been previously fulfilled.

My advice to you all is, never take such responsibility. After all, we physicians did not make the laws nor were we consulted when they were being made. We are, however, expected to obey them. Medicinal or physical restraint may only be safely used after observance of the legal formalities.

The physician may be asked to sign the Petition to Detain. My advice is that he refuse to do so. Though the law now states that he cannot be sued for so doing, there is at the present time such a suit in the courts. The signing of the Petition to Detain is the direct responsibility of the next of kin or of the most interested party. If no such person is available, and the situation is urgent, call the police and place the responsibility on their shoulders. If the case is not an emergency one, the Los Angeles Police Force has an officer to whom these problems may be referred. This officer in charge of psychiatric matters for the police will, if notified, investigate the situation and take the action he deems necessary. The physician has done his duty, and is relieved of further responsibility in the matter.

In summary, the relationship between the internist and the psychiatrist is rightfully a close one. Still greater coöperation and mutual understanding are desirable. Emergency cases falling to the internist should be handled with due emphasis placed on the legal requirements just discussed.

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ERYTHROBLASTOSIS FETALIS*

REPORT OF CASE

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INTRODUCTION.—Between one in 500 and one in 1000[1,2] newborn babies show a marked dysfunction of the blood-forming and blood-destroying systems of the body, which may be exhibited in a number of ways, all grouped under the general heading of erythroblastosis fetalis. The common feature of these cases is the presence of (1) abnormal islands of blood-forming tissue in the liver, spleen, kidneys, and others organs;

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(2) excessive numbers of immature erythrocytes in the circulating blood; (3) increased destruction of erythrocytes; and (4) a distinct tendency for the disease to appear in successive children of a family.

The three forms which the disease may exhibit are (1) icterus gravis neonatorum; (2) congenital anemia of the newborn; and (3) congenital hydrops, or universal edema of the fetus. Although these three conditions have been known individually for years, it has been only within the last decade that their common background has been recognized. Diamond and his associates,[3] in 1932, reviewed the literature and presented twenty cases to illustrate the point. Despite the underlying pathological process (disturbance of the blood-forming system) and the appearance of anemia in all three conditions, each presents a quite distinct symptomatology.

In icterus gravis the infant may appear entirely normal at birth, but within a few hours or days develops a marked jaundice and anemia, with many circulating nucleated red-blood cells and an enlarged liver and spleen. The bleeding time becomes prolonged, the anemia becomes progressively more severe, and, if untreated, the infant usually dies within one or two weeks.

In congenital anemia, the most striking feature is an anemia of increasing severity, accompanied by marked evidence of blood formation and destruction. The chief difference between this form of erythroblastosis fetalis and icterus gravis is that, in congenital anemia, the anemic process tends to overshadow the jaundice. In this connection Hellman and Hertig,[4] after reviewing 35 cases of erythroblastosis fetalis in 30,000 births, came to the conclusion that congenital anemia is merely a sequel to icterus gravis.

The gravest form of erythroblastosis fetalis is the so-called congenital hydrops, or universal edema of the newborn. The nature of this condition is illustrated by the following case, which was referred by Dr. Edward Liston of Palo Alto.

REPORT OF CASE

Baby girl, W., was born spontaneously at term on August 1, 1940. The prenatal course had been normal, and tests for syphilis and Bacillus abortus agglutinins on the mother had been negative. The mother, aged 29, had had three previous pregnancies. The first child, born in 1933, appeared normal at birth and had a negative cord Wassermann, but died a few days later. A five-and-one-half month abortion occurred in 1934 and a three month abortion in 1936.

Immediately upon delivery of Baby W., it was obvious that the child was not normal, and consultation was sought. The infant was examined by one of us (R.D.C.) fifteen minutes after birth. It was extremely pale, with large ecchymoses over the face and smaller ecchymotic spots on the trunk and extremities. The body was mildly edematous and the placenta markedly so, being about twice normal size. Respirations were irregular. The liver edge was smooth and firm, and extended below the umbilicus. A diagnosis of erythroblastosis fetalis, hydrops type, was made, blood specimens were taken for examination, and the infant was immediately given an intravenous transfusion of sixty cc. of matched uncitrated blood. Despite this treatment, death occurred within one hour after birth.

The laboratory reports showed a marked anemia with a red count of 900,000 and hemoglobin of 32 per cent (5.5 grams). There was a considerable excess of nucleated red cells, and there were many abnormally large red cells. Very few platelets were noted. The leucocyte count was 26,000, of which 12 per cent were immature forms. The coagulation time was seven minutes, and the bleeding time over five and one-half minutes. The blood was type II (Moss). An autopsy and pathological examination were done by one of us (B.L.D.), with the following findings: An unusually large placenta, weighing 1110 grams, was composed of huge firm cotyledons, white on section, which were separated by deep fissures. The broad cord and an accessory placenta added another 190 grams. Histologically the villi were large and had highly cellular edematous vacuolate stroma. Some of the peripherally arranged blood vessels contained nucleated red cells. In general, the microscopic appearance was more that of a midterm than a full-term placenta, and was typical of congenital hydrops. The stroma of the cord was edematous, and nucleated red cells were seen in the vein, but the arteries were empty.

The markedly livid newborn female body was slightly edematous and, with the exception of a greatly distended abdomen, showed no superficial congenital malformation. It weighed 2604 grams. The fetalplacental ratio thus was 2:1 instead of the usual 6:1. Microscopically, the myocardium was composed of the usual immature cardiac muscle cells, with scattered small interacellular glycogen deposits revealed by special stain. The amount was not sufficient to indicate glycogen storage disease. A few normoblasts were seen in the capillaries, but no blood islands were demonstrated.

A tremendously enlarged liver weighed 380 grams and distended the abdomen. Its capsule was smooth and glistening. The parenchyma was a dark purple. Many large clumps of nucleated red cells were seen in the sections. These filled and distended the sinuses, which were surrounded by parenchymal cells laden with granular brown pigment, indicating blood destruction.

The large eighty gram spleen was tense with blood. Myriads of immature erythrocytes in a fine collagenous stroma were seen in the sections.

Kidneys of normal size, weighing twenty grams each, showed clumps of nucleated red blood cells.

Elsewhere clumps of young red cells were seen in the lymph nodes and adrenals, and sections of the bone marrow showed very active blood formation.

To summarize: the pathological examination revealed edema of the placenta and marked evidence of blood destruction and widely-scattered blood formation.

COMMENT

Etiology.—It is obvious from the above descriptions that there is a common underlying pathology of the three forms of erythroblastosis fetalis, namely abnormal blood formation and destruction. As to the actual etiology of the disease, numerous theories have been advanced. One of the earliest (1935)[5] was the persistence of embryonal blood-forming foci in various organs. Other theories have included the exhaustion of a maternal hormone necessary for the stimulation of fetal blood formation.[6] A dominant mutation has also been suggested as the cause of the disease,[7] but the statistics on which this theory is based have been challenged.[8]

Diamond and his associates[3] have explained a number of the symptoms of the disease, and have pointed out that the icterus is due to abnormal destruction of immature red cells, plus clogging of the liver with blood pigment to produce an

obstructive jaundice. They have suggested that the edema is due to capillary damage produced by anemia and anoxemia. Weinberg [9] found elevated blood ureas in three cases of erythroblastosis fetalis, and suggested renal failure as the cause of the edema.

An interesting explanation of the etiology of the disease was made in 1938 by Darrow,[5] who argued that the fundamental pathological processes of erythroblastosis fetalis are abnormal destruction of erythrocytes and dysfunction of the liver due to injury. She attributed both the red cell destruction and liver damage to anaphylaxis, that is, sensitization of the fetus to antibodies formed in the mother's blood, following escape of fetal hemoglobin into the maternal circulation. This concept is especially interesting in the light of work reported this year by Levine and his associates,[16] on transfusion accidents in recently-delivered mothers due to atypical blood agglutinins. In studying five such cases, they found that three had given birth to infants suffering from erythroblastosis fetalis. Their hypothesis is that the mother becomes immunized to certain fetal factors possibly inherited from the father, and that, under certain conditions, the resulting agglutinins are able to pass the placental barrier and enter the fetal circulation, where they act upon "the blood cells and, perhaps, tissue cells of the fetus."

Diagnosis.—In severe cases diagnosis is often possible at birth, especially in congenital hydrops, where the appearance is startling, with icterus or marked pallor, edema, hemorrhagic spots over the body, and a huge placenta. A yellow amniotic fluid and vernix caseosa have been referred to as diagnostis guides, but they are apparently unreliable.[4] As a matter of fact, it has been stated that congenital hydrops can be diagnosed prenatally by use of the x-ray. In general, erythroblastosis fetalis should be suspected if the placenta is unusually large, or if it is pale and friable [11, 12], as in our patient.

Cases of icterus gravis and congenital anemia are sometimes impossible to diagnose at birth,[13] but soon develop a jaundice and anemia far more severe than are found in ordinary icterus neonatorum, together with an enlarged liver and spleen. The only certain methods of early diagnosis in these two forms of erythroblastosis require skilled pathological or laboratory study. The first is a microscopical examination of the placenta, which reveals characteristic enlargement of the placental villi, and epithelial vacuolization.[13] The second is counting the nucleated red cells, which has been found significant by Monfort and Brancato,[14] who noted that an excess of nucleated erythrocytes at birth, with failure to drop to normal by the second day, was diagnostic of erythroblastosis fetalis.

Therapy.—Once the diagnosis has been established, treatment becomes a matter of urgency, at least in cases of icterus gravis and congenital anemia. So far as we know, no therapeutic measures have saved any case of congenital hydrops.[4] The only procedure of proven efficacy in icterus gravis and congenital anemia is the use of matched blood transfusions. These should be intravenous rather than intramuscular, of sixty to eighty cc. in volume, started early, and repeated frequently —every day or so. Until more is known concerning the rôle of isoimmunization in the etiology of erythroblastosis fetalis, the donor probably should not be a member of the immediate family. Transfusions, if begun early, may prevent the anemia of icterus gravis, and may abort the abnormal erythroblastosis, according to Cohen.[15] Hellman and Hertig [4] reported that, in their series of twenty cases of icterus gravis, the deaths of ten were due to failure to transfuse, or to transfusions given inadequately or too late.

Recently Mayman [10] has reported on the use of vitamin K in the treatment of one case of icterus gravis. The vitamin was given on the ninth postnatal day, and within twelve hours the stools, which had been clay-colored, became and remained yellow. After several more days the jaundice began to clear and the baby began to improve generally. Whether this clearing up of what was apparently in part an obstructive jaundice was due to the vitamin K or would have occurred anyway, remains a matter for conjecture until further cases are reported. Personally, we feel that transfusions should be relied upon.

Prophylaxis.—As to prophylaxis, very little can be suggested. Adams and Cochrane [17] reported a family of three children, all born to the same mother. The first died two hours after birth of cerebral hemorrhage. The second developed icterus gravis, which was successfully treated with frequent blood transfusions and concentrated liver extract intramuscularly. During the last seven months of her third pregnancy, the mother received repeated intramuscular injections of concentrated liver extract and gave birth to a normal infant. Since the incidence of recurrences of icterus gravis in families is about eighty per cent, this use of liver extract prophylactically may have had some significance. At any rate, the only other certain method of avoiding subsequent cases of erythroblastosis fetalis in a family is to prevent further pregnancies.

In Conclusion.—As a final word, we should like to point out, once again, a few of the more important features of the disease. First, it may assume any one of the three forms which we have discussed; second, a study of the literature pretty well indicates that if we lump the three forms together for statistical purposes, erythroblastosis fetalis is not an exceptionally rare disease; third, there is a very distinct familial tendency, especially in icterus gravis; and, finally, the only treatment of proven value is repeated blood transfusions.

SUMMARY

1. Icterus gravis neonatorum, congenital anemia, and congenital hydrops are manifestations of erythroblastosis fetalis, a congenital disease of the newborn characterized by abnormal blood formation and destruction.

2. The gravest form of the disease is congenital hydrops, a case of which is reported.

3. The various theories of etiology, including isoimmunization, are reviewed.

4. Diagnosis is obvious in congenital hydrops; but in icterus gravis and congenital anemia the characteristic jaundice and anemia may be delayed until a few hours or days after birth.

5. The only effective therapy is early and frequent intravenous transfusions of blood, preferably from a donor who is not a member of the immediate family.

261 Hamilton Avenue.

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PROPOSED PLAN FOR MOBILE BLEEDING UNITS IN NORTHERN CALIFORNIA*

IRWIN MEMORIAL BLOOD BANK OF THE SAN FRANCISCO COUNTY MEDICAL SOCIETY

2180 Washington Street
San Francisco, California
(Telephone Walnut 5600)

To the Editor:—The American Red Cross originally asked for a quota of 10,000 units of blood from the Northern California Procurement Center. This quota is now a thing of the past—war has been declared—quotas are out, and we will keep on drawing blood until this conflict is over.

In order to augment our San Francisco supply, and to allow all Northern California communities large and small to participate in this fundamental Red Cross program we will send out small mobile bleeding units from the Irwin Memorial Blood Bank in San Francisco. This bank has been designated the official procurement center for Northern California.

Each motorized unit will have an ice box capacity for 80 to 120 units of blood, and adequate storage space for the necessary medical and secretarial supplies. The personnel for each unit will consist of one of our Blood Bank nurses, a volunteer chauffeuse, a technical assistant, and a recording secretary.

Our tentative plan for operation is as follows: San Francisco will be the hub of the wheel; towns distant to San Francisco will be plotted on the spokes radiating to the north, to the south, and to the east. One, or more doctors from those communities closest to the hub will be asked to visit the Irwin Memorial Blood Bank to see the technique we have developed for blood-letting, in order that their method will conform with ours.

On a certain day, chosen at least two weeks in advance so that the local Red Cross or some other responsible agency can sign up the requisite number of donors, the mobile bleeding unit will be sent to an adjacent town, and the doctors of that town who have had a "refresher course" in drawing blood at our Bank will perform the actual bleeding. Our specially trained nurse will not only assist the local doctors, but she will be available to answer pertinent questions as to technique etc. While the mobile bank is in operation at the above town two or more doctors from towns yet distant from San Francisco and the town where the drawing is in progress will be asked to attend in order to watch the proceedings and then to actually bleed a few donors. This controlled progression from the center will carry our uniform technique throughout Northern California. The reasons why such a policy must be carried out are:

1. There are too few doctors available, due to the national emergency, to adequately man the vehicles necessary for this large scale program.

2. Expense would be too great; if doctors *were* available for such medical personnel, they would have to be full time and salaried.

3. Voluntary donors will have more confidence in their local doctors and this fact will augment the response.

Medical men in each community will choose those doctors best fitted for intravenous work. This can be accomplished through the various County Medical Societies. Each society must see to it that a proper equalization of effort is made, as the plan must not bear heavily on the few for its success, but all work must be evenly distributed.

The medical profession of Northern California has been asked to help this new widely disseminated plan for collecting blood for the U. S. Army and Navy and to aid in creating a supply to be used in any national disaster. We can point the way for other states, as our plan is unique in its simplicity. Its full success will depend on three factors:

1. Full support of all doctors in making their community 100 per cent donor conscious.

2. Absolute adherance to the technique which we have evolved for drawing blood by the vacuum "closed" method.

3. Vigilant attention to routine orders by all parties concerned so that perfect coordination between Headquarters and all distant drawing points can be scrupulously maintained.

Please keep in touch with your local Red Cross Chapter. Do not hesitate to write me, but in a short while comprehensive instructions will be sent to the proper local medical authorities. Visit our Blood Bank if you are in San Francisco and see the greatly expanded project—you are always welcome.

(Signed) JOHN R. UPTON, M. D., *Secretary-Treasurer, Irwin Memorial Blood Bank; and Technical Supervisor, Red Cross Procurement Center.*

* For other comment on Irwin Blood Bank, see page 9.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Sec'y-Treas. and Editor
JOHN HUNTON.....Executive Secretary

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Russel V. Lee, Palo Alto.

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Plastic Surgery:
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Neuropsychiatry:
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Olga Bridgman, San Francisco.

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Clinton H. Thienes, Los Angeles.

† For complete roster of officers, see advertising pages 2, 4, and 6.

OFFICIAL BUSINESS

EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION*

Digest of the minutes of a meeting held in San Francisco, on Wednesday, November 26, 1941, and approved by mail vote.

The meeting was held in the offices of the California Medical Association at 450 Sutter Street, San Francisco, on Wednesday, at noon, November 26, 1941.

Activities of Certain State Boards.

Activities of various public boards were considered, but no action was taken.

Speeches of an Exchange Professor at U. C.

Dr. Makinson called the attention of the Committee members to speeches being made by an Exchange Professor of the University of California.

After discussion, it was agreed that the Committee on Public Health Education, through its Chairman, Dr. Frank R. Makinson, should send to the component societies and the members of the C. M. A. Council a digest of a recent speech delivered at Berkeley, at which two stenographers took some notes.

Portrait of First President of State Medical Association.

On behalf of Dr. Morton R. Gibbons, Sr., Chairman of the Committee on History, a letter from Mrs. J. E. Hays, Historian of the State of Alabama, and having date of November 21st, was submitted.

Mrs. Hays stated she was the granddaughter of the late Benjamin F. Keene, first President of the Medical Society of California (1856), and that for years she had been striving to have a copy made of a painting possessed by a great granddaughter of Dr. Keene, so that California might come into possession thereof.

Mrs. Hays stated that she had found an artist with whose work she was familiar and that she thought a copy of the painting could be made for $50.00.

In line with the action taken by the last House of Delegates for the collection of memorabilia, Dr. Gibbons, Chairman of the Committee on History, recommended that a sum not to exceed $75.00 be allocated to secure a copy of the painting, and, if available, photographs.

Because of the urgency of these conditions and owing to the fact that the California Medical Association did not possess a photograph of its first President, it was agreed that such allocation should be made.

Regarding Proposed Letter of Criticism of C.P.S.

The attention of the members present was called to a letter having date of November 18th, received from an Oakland colleague, in which permission was asked to print in CALIFORNIA AND WESTERN MEDICINE an article "criticizing the present organization (California Physicians' Service) and its policies."

It was stated that a letter had been sent to the Oakland

* Full minutes of the Executive Committee have been mailed to all councilors, and copies are also available for inspection in the central office of the Association.

physician calling attention to the rules laid down in the Council's brochure, "Suggestions to Authors," under Item 1 on page 4, and under Item 13 on page 7.

This subject and policies were discussed and it was agreed that Dr. Makinson, who was present, should confer with the physician who had written the letter.

Letter to Component County Societies.

In view of the number of requests that have been received from various organizations asking for appointment of members of the medical profession to State and county committees having to do with defense activities in the present emergency, it was agreed that a letter should be formulated and sent out by the Executive Committee, wherein request would be made of component county societies that they refrain from appointments or commitments to organizations or committees having to do with national defense, in cases not involving emergency or urgency, until approval in connection therewith has been given by the California Committee on Medical Preparedness, of which Dr. Harold Fletcher of San Francisco is Chairman. The draft of the letter follows:

The County Medical Societies,
Addressed.

Dear Doctors:

This letter, addressed to the forty component county societies of the California Medical Association, is a request from the C. M. A. Council, asking each county society to observe certain procedures before nominations or appointments are made for local committees or organizations aiming to aid in the work of national, state, or community defense.

In order to avoid confusion and duplication, and also to permit the Association officers to maintain proper contacts with all defense activities in which the medical profession is involved, the Council suggests and requests each county medical society to observe the following procedure:

1. Refrain from appointing or promising to appoint county society members on committees or organizations, until after the request has been submitted to the California Committee on Medical Preparedness (Chairman. Harold Fletcher, M.D., 450 Sutter, San Francisco). As promptly as possible, when such requests, with informative data, are submitted, Dr. Fletcher will seek to reply.

If a procedure such as is above outlined, is not observed, the medical profession in various communities may find itself associated with agencies that are not in accord with the medical standards laid down by the United States Army and Navy. Ill-advised cooperation may make for inefficient service to our Country.

The medical profession, as in the past, wishes to serve in most efficient manner, and this aim can only be realized when proper standards and affiliations are maintained. The Medical Corps of the Army and Navy, through the standards they have set, indicate the paths we should follow.

Respectfully submitted,
THE EXECUTIVE COMMITTEE OF THE CALIFORNIA MEDICAL ASSOCIATION.
Elbridge J. Best, M. D., *Chairman.*
George H. Kress, M. D., *Secretary.*

Attest:
Henry L. Rogers, M. D., *President*
Philip K. Gilman, M. D., *Council Chairman*

Letters Regarding Cost of Electrocardiograms of Selectees.

The Association Secretary reported on the replies that had been received from physicians to whom letters had been sent concerning suitable price for electrocardiograms of selectees. (Reference: Item 9(d), page 257, November C. & W. M.). These were turned over to the Chairman of the Executive Committee for consideration and recommendation.

ELBRIDGE J. BEST, M.D., *Chairman.*
GEORGE H. KRESS, M.D., *Secretary.*

Life Membership in California Medical Association

The constitutional amendment providing for C. M. A. life membership was submitted by Robert A. Peers, of Colfax in 1940, and was approved by the C. M. A. House of Delegates on Wednesday, May 7, 1941.

Component County Societies may wish to adopt somewhat similar membership privileges to cover county society membership.

(*e*) LIFE MEMBERS

(Amendment to Article IV, Section 1, of C. M. A. constitution.)

Qualifications: Life members of the California Medical Associations shall be elected by the Council on the recommendation of any component county society from those active members thereof who

(1) have been active members of this Association continuously for a period of twenty (20) years or more and are more than fifty (50) but less than sixty (60) years of age and have tendered to this Association a life membership fee of one hundred fifty (150) dollars;

Or (2) have been active members of this Association continuously for twenty-five (25) years or more and are more than sixty (60) but less than sixty-five (65) years of age and have tendered to this Association a life membership fee of one hundred (100) dollars;

Or (3) have been active members of this Association continuously for a period of twenty-five (25) years or more, are more than sixty-five (65) but less than seventy (70) years of age and have tendered to this Association a life membership fee of fifty (50) dollars;

Or (4) have been active members of this Association continuously for twenty-five (25) years or more and are more than seventy (70) years of age.

Those active members falling within Classification 4 need not be recommended by any component county society, but are eligible to life membership on direct application to the Council. The Council may not elect to life membership any active member whose membership has not been continuously or who has ever been censured, suspended or expelled from the American Medical Association, this Association, any state medical association which is a constituent unit of the American Medical Association, or any county medical society which is a component part of this Association or a unit of any other state medical association.

***Obligations and Rights.*—Life members shall not pay dues and shall not be liable for assessments of any kind or nature. If active membership in good standing is maintained in his component county society, each life member shall have the right to vote, to hold office, and shall have all other rights and privileges of the Association. If active membership in his component county society is not maintained, the rights and privileges of a life member shall be those of a retired member.**

Now more than ever before, public health workers must assume new responsibilities and be ready to adapt themselves quickly to what may lie ahead. National defense is a powerful additional reason for intensifying and extending our public health program and for a rigorous self-analysis of our work.—JOHN L. RICE, M.D., *Commissioner of Health, New York City.*

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* In this printing, additional paragraphs have been used, for greater convenience in reference.—Editor.

ANNUAL CONFERENCE: STATE ASSOCIATION OFFICERS AND COUNTY SOCIETY SECRETARIES

On Sunday, January 18th, in the Empire and French rooms of the Sir Francis Drake Hotel in San Francisco, an all-day conference of officers and members of the standing committees of the California Medical Association will be held with secretaries of component county medical societies. Program follows:

6th Annual Secretarial Conference: Agenda

FOR MEETING TO BE HELD:

Day and Date: Sunday, January 18, 1942.

Hours: 9:00 a.m. to 5:00 p.m.

Place: Sir Francis Drake Hotel, Sutter and Powell, San Francisco.

REQUESTS

(1) Please pass in your registration slip at the table marked *Registration*, in the French Room (second floor entrance room).

(2) Speakers, in rising to discuss a paper, are requested to give their names, and official positions.

(3) A typewritten copy of each report submitted, should be handed to the Secretary, for placing in the C.M.A. files.

(4) Paper slips on the chairs are for questions (if you wish to send them to the platform). Questions should be signed with name, and official position.

(5) Questions are invited at the end of each report.

PART I.—PRELIMINARY COMMITTEE MEETINGS: 9:00 A.M.

Members of Standing and Special Committees are requested to meet at 9:00 a.m. for informal conference and discussion of their committee work as outlined in the by-laws. (Pages 38-45; Chapter V, Section 1-22.)

PART II.—MORNING SESSION: IN EMPIRE ROOM

President Henry S. Rogers, Petaluma, presiding.

I.—10:00 a.m.—*Introductory Remarks:* by President Henry S. Rogers.

II.—10:10 a.m.—*C.M.A. Committee on Public Relations.*

(a) Report by Donald Cass, Committee Chairman.

III.—10:25 a.m.—*Committee on Public Health Education.*

(a) Report by Frank R. Makinson, Committee Chairman.

IV.—10:45 a.m.—*California Physicians' Service.*

(a) *Progress Reports and Talks:*

(1) Ray Lyman Wilbur, President, Board Trustees.

(2) T. Henshaw Kelly, Member, Board of Trustees.

(3) Albert E. Larsen, Secretary and Medical Director.

V.—11:00 a.m.—*Medical Preparedness.*

(a) *Reports by:*

(1) Harold A. Fletcher, Chairman of the California Committee on Medical Preparedness.

(2) Charles A. Dukes, Member of Committee on Medical Preparedness of the American Medical Association.

(b) *Informal Addresses:*

(3) A Representative of the Medical Corps of the U. S. Army.

(4) A Representative of the Medical Corps of the U. S. Navy.

(5) A Representative of the U. S. Public Health Service.

(6) A Representative of the Office of Civilian Defense.

(7) A Representative of Selective Service Activities.

(8) A Representative of the Medical Corps of the California State Guard.

(9) Summary by Captain Philip K. Gilman, U. S. Navy, former chairman of the C.M.A. Committee on Medical Preparedness.

(Questions Invited)

VI.—12:00 a.m.—*C.M.A. Committee on Public Policy and Legislation.*

(a) *Progress Reports by:*

(1) Dwight H. Murray, Chairman.

(2) Junius B. Harris, Chairman Advisory Committee.

(Questions Invited.)

PART III.—NOON LUNCHEON AND REST PERIOD

12:30 Noon—*Recess for Luncheon.* In French Room (lobby to Empire Room).

Luncheon is scheduled for 12:30 noon.

(If program listed for the Morning Session is not completed, same will be carried over for the Afternoon Conference.)

* * *

VII.—2:00 p.m.—*Public Health League of California.*

(a) Report by Mr. Ben Read, Executive Secretary.

VIII.—2:15 p.m.—*Council of the California Medical Association.* Philip K. Gilman, Chairman.

IX.—2:30 p.m.—*Reports by California State Boards:*

(a) *California State Board of Medical Examiners,* Dr. Charles B. Pinkham, Secretary.

(b) *California State Board of Public Health,* Dr. Bertram P. Brown, Director.

X.—3:00 p.m.—*Reports by C.M.A. Standing and Special Committees:*

(Five-Minute Progress Reports.)

(a) *Committee on Associated Societies and Technical Groups.* John V. Barrow, Los Angeles, Chairman.

(b) *Committee on Health and Public Instruction,* John Ruddock, Los Angeles, Chairman.

(c) *Committee on History and Obituaries,* Morton R. Gibbons, Sr., San Francisco, Chairman.

(d) *Committee on Hospitals, Dispensaries and Clinics.* J. Norman O'Neill, Los Angeles, Chairman.

(e) *Committee on Industrial Practice.* Donald Cass, Los Angeles, Chairman.

(f) *Committee on Medical Defense,* Nelson Howard, San Francisco, Chairman.

(g) *Committee on Medical Economics,* Glenn Cushman, San Francisco, Chairman.

(h) *Committee on Medical Education and Medical Institutions,* Loren R. Chandler, San Francisco, Chairman.

(i) *Committee on Membership and Organization,* Louis Alesen, Los Angeles, Chairman.

(j) *Committee on Postgraduate Activities,* Dwight L. Wilbur, San Francisco, Chairman.

(k) *Committee on Scientific Work*—(Annual Session), George H. Kress, San Francisco, Chairman.

(l) *Committee on Publications,* A. A. Alexander, Oakland, Chairman.

(m) *Editorial Board,* Russell V. Lee, Palo Alto, Chairman.

(n) *Cancer Commission,* Charles A. Dukes, Oakland, Chairman.

(Questions Invited.)

XI.—OTHER ACTIVITIES:

(a) *Houses of Delegates*—(American Medical Association, and California Medical Association).

(1) Comments by Lowell S. Goin, Speaker, C.M.A. House of Delegates.

(2) Comments by A.M.A. Delegates (Elbridge J. Best, Lyell C. Kinney, Edward N. Ewer, Edward M. Pallette, Robert A. Peers, William R. Molony, Sr., Harry H. Wilson, and Henry S. Rogers.)

(b) *Reports of Special Committees:*

(1) *On Needy Members*—Axcel E. Anderson, Chairman.

XII.—QUESTION BOX HOUR: "THE GOOD OF THE ASSOCIATION".

(If time permits, and until adjournment hour is reached, the remainder of the afternoon session will be given over to questions on matters pertinent to "The Good of the Association". [In relation to scientific or organized medicine, or of national, state, county, local nature]. Questions should be submitted in writing. In rising to speak, please give name and official position.)

* * *

ADJOURNMENT.

HENRY S. ROGERS, *President*
PHILIP K. GILMAN, *Council Chairman*
GEORGE H. KRESS, *Association Secretary.*

* For editorial comment, see page 3.

CALIFORNIA COMMITTEE ON MEDICAL PREPARDEDNESS†

California Medical Statistics: Re Medical Rejections of Selectees

The California Department of Selective Service, under date of December 12, 1941, issued a report on the Medical Results noted in the examination of 60,839 male citizens who were examined under the Selective Service Act. The sum...ary showing the break-down for the entire group, and the percentage of rejections for each of the 283 Local Selective Service Boards follows:

State Headquarters Selective Service
State of California
Plaza Building
Sacramento

December 12, 1941.

MEDICAL RESULTS

Medical Inspection for screening is now our procedure. It is interesting to review the final figures showing the results obtained by our Boards and their Doctors under the old plan of "primary selective service medical examination and classification" before presenting registrants to Army Examiners at Induction Stations:

REJECTIONS AT INDUCTION STATIONS

We presented 60,839 Selectees to Induction Stations and were rejected there (8.92%).	5,430
Rejections for physical and mental reasons (excluding illiterates)	8.33%
Rejections for reasons other than physical or mental (includes illiterates)	.59%
PERCENTAGE OF REJECTIONS FOR THE STATE....	8.92%

TABLE 1.—*Breakdown of This 8.92 per cent Rejected*

Eyes (vision principally)	11.5%
Teeth (number, pyorrhoea, malocclusion)	9.5
Weight (mostly underweights, very few overweights)	4.
Ear (o.m.c.c., membrane)	7.5
Cardio-vascular (Heart, Blood Pressure, Pulse)	3.5
Spine, Joints	3.
G. U. (Venereal, G. C., Lues, Testicle)	5.
Abd. organs (Hernia, G. B., Appendix, Rectum)	5.5
Nose, Mouth (Larynx, Septum)	2.5
Neuro-Psychiatric	16.5
Extremities (Digits, Muscles, Pes Planus, Varicose Veins, Fract.)	14.
Lungs	9.5
Endocrine (and skin)	2.
Other than physical (Illiteracy, Felonies, Dishonorable Discharge, Inaptitude)	6.
	100 %

* * *

TABLE 2.—*For Table 2, see next page*

* * *

TABLE 3.—*Selective Service Medical Personnel Recommendations After Examination*

1A		50%
1B—Eyes	5.1%	
Teeth	3.	
Weight	3.6	
Ear	.5	
Spine—Joints	.7	
G. U.—Venereal	2.1	
Abd. Viscera	.4	
Hernia	3.	
Nose—Mouth	1.6	
Nervous—Mental	.01	
Extremities	2.5	
Flat Feet	2.4	
Varicose Veins	.6	
Skin	.01	
Lungs	.6	
Endocrine	.01	
Acute Diseases	.08	
Other than physical	.01	
	26.22	26%
4F—Eyes	1.5	
Teeth	.4	
Weight	1.2	
Ear	2.	
Cardio—Circ.	8.1	
Spine—Joints	.7	
G. U.—Venereal	.7	
Abd. Viscera	.6	
Hernia	.1	
Nose—Mouth	.1	
Nervous—Mental	2.	
Illiteracy	.8	
Extremities	2.2	
Flat Feet	.7	
Varicose Veins	.5	
Skin	.2	
Lungs	1.5	
Endocrine	.7	
Acute Diseases	.1	
Other than physical	.1	
	24.1	24%
		100%

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

Examination of Selective Service Registrants: New System now Operative in California

Physical examinations of selective service registrants have now been definitely taken over by the U. S. Army Recruiting Service in California. The new examination procedure will take a heavy load from the shoulders of physicians who have been rendering much gratis service in the past in performing physical examinations of a screening character.

Under the Army recruiting service setup, a traveling board from Army headquarters will schedule physical examinations of registrants in convenient urban centers, where local physicians will be asked to cooperate with Army medical men in forming examining teams.

The Army, traveling board will consist, in all cases, of a head examining physician, one medical specialist, one dentist, and necessary clerical personnel. Local communities where draft examinations are to be held will be asked to furnish four additional medical specialists who will work with the Army doctors as an examining team. Teams of this character can perform from 100 to 150 physical examinations in a relatively short working day.

The Army recruiting service now has three traveling boards operating from Northern California headquarters in San Francisco, one from Southern California offices in Los Angeles.

The ideal examining team will consist of the head examining physician (an Army doctor), a surgeon, an internist, an ophthalmologist, an otolaryngologist, and a neuropsychiatrist, together with the dentist and clerical personnel who complete the traveling board. The physicians on the traveling board include the head examiner and one specialist; local communities will be asked to supply the other specialists, with the provision that a team may be completed without the neuropsychiatrist if one is not available.

Local members of the examining teams will be paid a per diem of $15.

* * *

Calls have already gone out from the C. M. A. office to eight counties in Northern California where draft examinations are scheduled for January. These counties, together with the city of examination, dates and number of examinations, are as follows:

County	*City*	*Dates*	*Examinations*
Shasta	Redding	Jan. 6-9, inc.	100 daily
Yuba	Marysville	Jan. 12	100 daily
Sacramento	Sacramento	Jan. 19-22, inc.	100 daily
San Joaquin	Stockton	Jan. 6-8, inc.	133 daily
Fresno	Fresno	Jan. 12-16, inc.	120 daily
Santa Clara (Two periods)	San Jose	Jan. 6-9, inc. Jan. 12-15, inc.	137 daily
Eureka	Santa Rosa	Jan. 19-20, inc.	100 daily
Sonoma	Humboldt	Jan. 23	100 daily

Other counties in California should be prepared to cooperate with recruiting service officials when registrants in other areas are called for examinations. The medical profession has criticised the old draft examination procedure and has long urged something like the new system. Now that it is here—and is destined to be greatly expanded under new military service age limits—it is incumbent on all physicians to do their utmost to make it work.

"Army Traveling Boards" for Final Selective Service Examinations: Outline of Procedures

Request was recently made of Lieut. Colonel Bert S. Thomas, M. C., Chief of the Medical Division of California State Selective Service, Plaza Building, Sacramento, for additional information concerning the National Headquarters order, effective January 1, 1942, relating to new procedures in final examinations of Selective Service registrants.

For the information of C. M. A. members who have special interest therein, the following reply and enclosure should be of interest:

(COPY)

STATE OF CALIFORNIA
DIRECTOR OF SELECTIVE SERVICE
Plaza Building, Sacramento

December 31, 1941.

Dear Doctor Kress:

Your information that an Army Traveling Board consisting of an Army Doctor, a Dentist and certain clerical personnel, is to conduct final examinations for the Selective Service, is correct. The examination conducted by the Army Examining Board is one which follows the examination as outlined in our MD-31 by the Selective Service Examiners.

Whereas, under the old scheme, the Selective Service Examiner made a complete examination of any registrant once committed for examination, now, the examination is a briefer one and is based on the finding of certain physical defects as outlined in a new Selective Service form known as DSS Form 220, and herewith attached. In other words, rather than the Selective Service Doctors examining a man completely to determine whether he did or did not have certain qualifications as outlined in Mobilization Regulations 1-9, and so determining whether, in his opinion, he was fitted for unlimited military

TABLE 2.—*Individual Board Records at Induction Stations**

(State Average, 8.92 Per Cent)

L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.	L.B.	% Rej.
1	19	58	8	115	9	172	6	229	7
2	9	59	8	116	10	173	8	230	8
3	6	60	5	117	11	174	9	231	15
4	12	61	11	118	5	175	11	232	10
5	8	62	4	119	9	176	8	233	7
6	6	63	14	120	13	177	8	234	7
7	9	64	5	121	10	178	8	235	9
8	9	65	5	122	14	179	9	236	7
9	7	66	8	123	8	180	6	237	6
10	11	67	5	124	10	181	6	238	8
11	9	68	7	125	7	182	4	239	12
12	6	69	4	126	5	183	9	240	7
13	15	70	7	127	7	184	9	241	7
14	8	71	8	128	10	185	12	242	6
15	6	72	7	129	10	186	3	243	8
16	9	73	16	130	6	187	10	244	9
17	4	74	6	131	7	188	7	245	12
18	12	75	13	132	14	189	9	246	9
19	6	76	7	133	11	190	3	247	9
20	11	77	9	134	8	191	4	248	8
21	8	78	10	135	13	192	9	249	9
22	10	79	11	136	14	193	11	250	5
23	6	80	8	137	11	194	8	251	9
24	13	81	9	138	10	195	8	252	7
25	11	82	8	139	9	196	8	253	6
26	6	83	5	140	10	197	8	254	9
27	6	84	8	141	10	198	12	255	13
28	4	85	8	142	8	199	9	256	9
28a	9	86	9	143	7	200	8	257	10
29	11	87	9	144	10	201	12	258	6
30	5	88	12	145	8	202	6	259	7
31	11	89	8	146	8	203	11	260	6
32	10	90	5	147	9	204	6	261	12
33	Zero	91	5	148	9	205	5	262	11
34	7	92	5	149	5	206	6	263	10
35	13	93	8	150	10	207	7	264	11
36	9	94	11	151	12	208	7	265	9
37	9	95	8	152	10	209	10	266	8
38	10	96	13	153	6	210	7	267	10
39	6	97	11	154	5	211	7	268	9
40	6	98	7	155	8	212	11	269	10
41	14	99	5	156	10	213	14	270	7
42	2	100	7	157	8	214	15	271	7
43	6	101	7	158	10	215	10	272	11
44	7	102	5	159	12	216	11	273	12
45	6	103	8	160	8	217	10	274	12
46	7	104	9	161	11	218	13	275	9
47	9	105	6	162	6	219	12	276	6
48	9	106	5	163	13	220	9	277	10
49	9	107	7	164	5	221	9	278	12
50	9	108	9	165	10	222	10	279	9
51	6	109	6	166	8	223	12	280	7
52	11	110	11	167	10	224	12	281	7
53	3	111	9	168	10	225	12	282	7
54	9	112	7	169	10	226	12	283	5
55	8	113	6	170	12	227	8		
56	7	114	5	171	10	228	8		
57	10								

* Symbols: L. B. = Local Board; Rej. = Rejections. (Serial numbers in sequence are the numbers of the 283 Local Boards in California, appointed by the Governor for examination of Selectees.)

duty—now, he merely excludes certain registrants from appearing before Army Examining Boards for final examination, by the discovery of those defects in DSS Form 220 which permanently fix a registrant in Class 4-F (completely disqualified for all military service), or in 1-B (qualified, at the best, for only limited military service).

It will mean that certain registrants will be selected by our medical personnel to be examined by Army Examining Teams, who will come back from those Army Examining Teams to be reclassified in either 1-B or 4-F classifications. For instance, the examination as conducted by our Selective Service personnel would not discover a registrant who had a perforated ear drum. This man, however, might not be deaf, nor might he even show any partial deafness. Such a man would be sent on to these Army Examining Boards only to be returned by them with a recommendation that he be put into Class 4-F (disqualified for all military service), and so would he remain, unless the qualifications were changed.

At the present time, there are two fixed Army Examining Boards—one in San Francisco and one in Los Angeles. In addition to the fixed Boards, there are several Traveling Boards. These Traveling Boards examine in eleven other cities. They include Redding, Marysville, Sacramento, Stockton, Santa Rosa, Eureka, San Jose, Fresno, Bakersfield, Santa Barbara and San Diego.

These teams will utilize Doctors in specialties to expand their examining personnel, in exactly the same manner as the previous Induction Teams were organized. For instance, a team might come into Sacramento and consist of an Army Doctor with whatever personnel he has available to bring into the city. He might need an Ear, Nose and Throat specialist, a Surgeon, an Internist, a Neuropsychiatrist, and others. These will be civilian Doctors receiving approximately the salary of a Major, just as they are receiving at the present time on Induction Boards.

Should there be any other information that we can give you, feel free to ask.

(Signed) J. O. DONOVAN,
State Director of Selective Service.

* * *

(COPY)

STATE HEADQUARTERS SELECTIVE SERVICE
STATE OF CALIFORNIA
Plaza Building, Sacramento

December 22, 1941.

To Doctors: (Copies to Local Boards)

PHYSICAL EXAMINATION—CLASSIFICATION—SELECTION

All Local Boards and Examining Physicians are acquainted with our previous *"Complete examinations"* of registrants required when a registrant was once committed to an examination. These examinations were replaced by a system of *"Screening-inspections"* which sent the bulk of registrants to Army Examining Stations for their complete examinations (Revised Induction Plan; DI-81-LB, 11-12-41)—All this was in accord with the training program and before the Declaration of War—

NOW,—National H. Q. advises us that, effective Jan. 1, 1942, the following will prevail. (This is resumed from National H. Q. Memo I-309, L.B. Release 66):—

The Examining Physician and Dentist will conduct the physical examination in such a manner as to determine those physical defects—

1—Which manifestly disqualify the registrant for military service (all); ("Fixed" 4-F's).

Or—2—Which manifestly disqualify a registrant for general military service but not for limited military service; ("Fixed" 1-B's).

[Such defects are prescribed respectively by Parts I and II of the List of Defects (Form 220) which will be distributed to you.

Upon physical examination, the Examining Physician will merely indicate whether or not he has found such defects, as above, to exist—by answering questions either "yes" or "no" to the following questions, which will be found written on page 4 of Form 200, temporarily—until the new consolidated form, Report of Physical Examination, Form 221, is issued and available:—

1—Do you find that the above named registrant has any of the defects shown on Part I of the List of Defects (Form 220)? (If in doubt, answer "no".) [If answer is "yes", this will suggest a "Fixed" 4-F recommendation.]

2—Do you find that the above named registrant has any of the defects shown on Part II of the List of Defects (Form 220)? (If in doubt, answer "no".) [If answer is "yes" and question 1 is answered "no", you will recognize that this will suggest a "Fixed" 1-B recommendation.]

If the answer should be "yes" to either question, the defect or defects found should be briefly described.

If the answers are "no" throughout, it will mean a 1-A recommendation. You will note from a study of Form 220 that many conditions which you now recognize as not 1-A, will bear a present 1-A recommendation—for—it is contemplated that remediable conditions, such as hernias, and such as "less-teeth-than-minimum" requirements for 1-A (unless edentulous), are to remain in Class 1-A (subject to induction after rehabilitated) even after Army Examining Board examinations. You will also note that certain conditions which might eventually be classified in 1-B after return from Army Examining Boards, will be sent to them even though you might recognize that they will eventually land in 1-B. Such an instance would be a non-correctable 20/200 eye without glasses; however, if he is not "blind" in one eye (as indicated in Part II, Form 220), he is sent to the Army Examining Station for the necessary refraction and complete examination.

The Local Board shall place no registrant in Class 4-F by reason of any physical or mental disqualification—before physical examination. However, when the Physician knows or learns of a *mental* disease, the Examining Physician may avail himself of any information obtained from social agencies, schools or hospitals, so that he might abstract said material on the report, under "Remarks" and thus guide the Board in its classification. The Physician may report to the Local Board on the case of a registrant who does not appear before him when he report is based on his professional knowledge of the mental incompetency, *and* the condition is such that it is inadvisable for the registrant to personally appear before the Examining Physician—or—the Examining Physician may accept an affidavit from a reputable physician as to such conditions, attaching the affidavit to the Report of Physical Examination.

THE EXAMINATION—In conducting the examination of the registrant to disclose the evidence of any defects as indicated in Part I and II of Form 220, the examination will be held with the registrant in the nude. The *physical examination should consist of observing the registrant while walking toward, standing before, and walking away from the Examining Physician.* The registrant may be required to go through calisthenics to determine the mobility of joints or to furnish a basis for determination of his alertness, intelligence, understanding of commands, postural tensions, tendencies to incoordination, and tremors. If peculiarities are noted, simple questions should be asked in an effort to bring out replies bearing on the mental health and personality characteristics of the registrant. The Examining Dentist, or, if not available, the Examining Physician will examine the mouth of the registrant. No blood will be taken for serological tests, and *no laboratory procedures will be undertaken* as a part of this physical examination.

The Examining Physician shall complete any entries in Section I of the Report of Physical Examination which were not completed by the Local Board—a memorandum having been sent with the original copy of Report of Physical Examination requesting the Physician to complete such entries after questioning the registrant.

Such procedures as commencement of classification, classifications before physical examination, reference for physical examination, Local Board preparation of Forms, classifications after physical examination, appeal, order to report for final examination and possible reclassification after physical examination by Armed Forces—all explained in National Memo I-309—are not discussed here, as this bulletin is issued only to present to the Doctors their part in the new plan, effective January 1, 1942.

For CULBERT L. OLSON, *Governor*,
(Signed) J. O. DONOVAN,
State Director of Selective Service.

Official Regulations—Re: Authorized Emergency Vehicles and Certificates

CIVILIAN DEFENSE REGULATION BULLETIN NO. 1

Sacramento, December 16, 1941.

Subject: Blackout Instructions For Motoring Public:

The following regulations are prescribed for all motor vehicles during blackouts:

1. Blackout Signals:

Upon receipt of the air raid warning "Air Raid Message—Red," a signal of two minutes' duration, consisting of either a fluctuating or warbling signal of varying pitch, or a succession of intermittent blasts of about five seconds' duration, separated by a silent period of about three seconds will be given.

Upon receipt of the all-clear signal, "Air Raid Message—White," a continuous signal of two minutes' duration at a steady pitch will be given.

2. When the blackout signal is given, immediately park off main traveled portion of the highway, turn out all lights, and walk to a place of safety. These conditions must be maintained until the all-clear signal is given.

3. No vehicle must be operated after receiving the blackout signal and during the blackout until the all-clear signal is given. Only emergency vehicles will be permitted to operate during blackout.

4. Emergency vehicles will be identified on the front by the regular blackout lamps.

5. No vehicles other than emergency vehicles should be equipped with blackout lamps or any masking material, such as blue or green cellophane, pliofilm, or other transparent material, as private vehicles are not permitted operation during blackouts.

These instructions have been drafted with the assistance and approval of the 9th Regional Office of Civilian Defense.

This is the same information contained in All Points Bulletin Teletype No. 13, Sacramento, December 12, 1941.

(Signed) JAMES M. CARTER, *Director*
Department of Motor Vehicles.

(Signed) E. RAYMOND CATO, *Chief*
California Highway Patrol.

(Signed) EARL WARREN,
Attorney General and Chairman
Civil Protection Committee
State Council of Defense.

(Signed) RICHARD GRAVES,
Executive Director, Calif.
State Council of Defense.

(Signed) MAJOR H. F. OSBORNE,
Actg. Asst. Director
9th Regional Office of Civilian Defense.

* * *

CIVILIAN DEFENSE REGULATION BULLETIN NO. 2

December 16, 1941.

Subject: Definition of Emergency Vehicles for Blackout Operation:

(A) Two classifications of Emergency Motor Vehicles have been established as follows:

Statutory Emergency Vehicles . . . .

Permitted Emergency Vehicles . . . .

(B) The Emergency Vehicles that will be permitted to operate during a blackout are as follows:

. . . 6. All vehicles certified by Sheriffs, District Attorneys, The California State Highway Patrol, Police Chiefs, and Fire Chiefs, when within the respective territorial jurisdictions of the certifying office, as being essential to the preservation of the public peace and safety or to the dissemination of public information or to the National Defense; provided, however, that such vehicles shall conform to the Uniform Lighting Regulations approved by the Department of Motor Vehicles and the California State Highway Patrol for Blackout Emergency Vehicles. No certificate shall be issued which conflicts with any regulation or order of the United States Army applicable in the area for which the certificate is issued.

(This bulletin contains the information sent out in All Points Bulletin, Teletype No. 1, San Francisco, December 15, 1941.)

JAMES M. CARTER, *Director*
Department of Motor Vehicles.

EARL WARREN,
Attorney General and Chairman
Civil Protection Committee
State Council of Defense.

RICHARD GRAVES,
Executive Director, California
State Council of Defense.

E. RAYMOND CATO, *Chief*
California Highway Patrol.

* * *

CIVILIAN DEFENSE REGULATION BULLETIN NO. 3

December 16, 1941.

Subject: Blackout Lights for Emergency Vehicles:

I. *Purpose of Blackout Lights.* Blackout lights are *only* useful as marker lights to warn approaching vehicles of the presence of another vehicle. They are not intended to produce enough light to reveal the roadway and obstacles. It is mandatory that vehicle speeds be reduced to a safe speed of not more than 15 miles per hour outside of cities and not more than 10 m.p.h. in cities under blackout conditions.

II. *The regular lighting system must be maintained* essentially as required by law, including headlamps, tail lamps, and license plate lamps.

The use of any masking device on headlights as a fixed installation is not permitted. The use of colored transparent material over the headlights is not permitted. You must maintain your vehicle in condition to operate safely in normal conditions.

III. *Commercially Manufactured Blackout Lights Are Not et Available.* The Department of Motor Vehicles will, from time to time in the future, pass upon particular blackout lighting devices submitted to it. Lists of approved devices will be issued for the guidance of the public.

IV. *Recommended Specifications for Conversion of Existing Vehicle Lighting.* The Department *recommends* the following:

A secondary and completely independent lighting system to be used for blackout operations. The blackout lighting system shall include two lamps, blue, amber or white, showing to the front (except motorcycles, only one required), and at least one red lamp showing to the rear.

To convert existing vehicle lights, apply the following rules:

RULE 1: All blackout lights must be shielded to eliminate all light above twelve degrees from the horizontal and must not be visible at more than 1000 feet at any angle. To check the adequacy of the shield, place your eye 36 inches away from and 8 inches up from a horizontal line through the lamp. From this point no direct light shall be visible.

(a) ON THE FRONT: Use parking lamps for front blackout lamps where these exist as separate lamps. Have sheet metal shields installed by your local mechanic. The shield must completely enclose the lamp and extend far enough forward and be tapered down at the opening to meet the angular requirement above. The inside of the shield must be painted matte black. Eliminate all reflections from the body or bright metal work.

To cut down the intensity of the blackout lamps either use an aperture in the shield or paint the lens with black or dark paint. For vehicles that do not have separate parking lamps, it will be necessary to mount extra lamps on the front in accordance with the above.

(b) ON THE REAR: At least one red rear blackout lamp must be used in the blackout operations. The lamp should be on the left side and must be shielded, and intensity diminished as in front lamps.

For vehicles with two tail lamps, use the right tail lamp for normal operation and modify the left tail lamp for blackout operation. The switching must be corrected so that the normal tail lamp is used only with the normal headlights.

RULE 2: A switch must be installed in the stop lamp circuit so that bright stop lamps are not operated under blackout conditions. The stop lamps are operated with the brake pedal and unless disconnected it will flash every time the pedal is used.

RULE 3: All license plate lights must be out in blackout operations. Cars equipped with a separate license plate lamp can be wired to switch this light off with the stop lights. Cars with a combination tail lamp and license plate lamp will have to use this lamp for normal operation only and provide a separate red rear blackout lamp.

RULE 4: The following accessory lamps must not be used or lighted during blackout operation: Emergency red lamps, spot lamps, auxiliary, fog, driving or passing lamps, identification lamps, running board lamps, cowl lamps, fender lamps, backup lamps, lamp type direction signals, and all other incidental and unnecessary lamps.

RULE 5: On trucks and trailers, the clearance lamps must be out during blackout operation.

V. *An Acceptable Blackout Lighting System, for Temporary Use by Emergency Vehicles in Lieu of the Recommended System.*

To provide an immediate blackout lighting system for those individuals who are *unable to afford* or *cannot secure* the recommended blackout lighting system, and for those persons who must equip a vehicle *now* and *with the facilities and materials* they can most readily obtain, the following rules are provided:

(a) Dark oil cloth or rubber masks or hoods may be securely attached to the head and tail lights of vehicles, with a horizontal slit in the lower portion, about 1/4" x x3". If this hood or mask is to be used over the regular headlight or tail light, it must be removed immediately after the blackout, or, if the attachment consists of a hood with a movable flap, the flap masking the front of the headlight must be moved back out of the range of the lights immediately after the blackout, so that the regular lighting system will not be impaired.

(b) An improvised ground light may be made by attaching, under the center of the vehicle body, a small can with a shaded bulb installed at the closed end. The open end of the can should point vertically down and the wiring should be arranged so that no other vehicle lights burn when the ground light is turned on. This type of light will silhouette the car sufficiently so that it can be seen by an approaching vehicle.

(c) Where the car has a separate set of parking lights, the blackout lighting system should be arranged on the parking light.

(d) If the parking light is used, the light from the top and sides should be masked out, either with black paint or with some covering device, and a shield of some material should be arranged to black out the front portion of the light, with the exception of a center opening not exceeding two inches in diameter.

(e) Care should be taken to mask stop lights which are connected with the brake pedal.

(f) All lights should be masked or blacked out or disconnected, except not exceeding two marker lights on the front or one or two marker lights in the rear, or the ground light beneath the car referred to above.

VI. *Red Lights and Sirens.* Stautory Emergency Vehicles only will be permitted to be equipped with red lights and sirens

and the granting of blackout operating permit does not permit the use of red light or siren upon a Permitted Emergency Vehicle. No emergency red light or siren may be operated by any emergency vehicle during a blackout period.

JAMES M. CARTER, *Director*
Department of Motor Vehicles.

E. RAYMOND CATO, *Chief,*
California Highway Patrol.

RICHARD GRAVES,
Executive Director, California
State Council of Defense.

Civilian Defense Insignia for Physicians and Nurses

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.
December 20, 1941

To the Editor:—The following material is sent to you for your information and for possible publication.

The Office of Civilian Defense has prepared insignia for volunteer civilian defense workers to wear after they have been enrolled and trained. There is one basic insigne bearing the initials "CD" in red, enclosed in a white triangle superimposed on a blue field, which is to be worn on cap and uniform collar ornaments of all civilian defense workers. Each of the fifteen activities has a distinctive design to be worn on white armbands or embroidered on the left sleeve of uniforms 1 inch below the shoulder seams. The designs have been patented by the OCD, and only enrolled civilian defense workers are entitled to wear them as part of uniforms or to any clothing that would simulate official wear. Workers or their defense councils will pay for the insignia with the possible exception of the armbands. Congress has been asked to authorize funds to distribute the latter.

Physicians and nurses serving in emergency medical field units will be identified by a red caduceus in a white triangle set in a blue circle. In the event of a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service. Field units composed of doctors, nurses and nursing auxiliaries will set up casualty stations near the site of disaster for the purpose of giving assistance to the injured and expediting their transport to a hospital when necessary. Teams of doctors, nurses and assistants will be dispatched from this station to establish advanced first aid posts closer to the scene of the emergency.

Volunteer nurses' aides will be identified by a red cross within a white triangle set in a blue circle. This indicates that the volunteer has been enrolled and trained by the American Red Cross for service in Civilian Defense.

Special training by the Red Cross and by hospitals designated as training centers is required of nurses' aides. When they have completed the prescribed instruction they will become eligible to assist nurses in wards and outpatient clinics of hospitals, or in visiting nurse, public health, industrial hygiene and school health services. The insigne must not be worn until the course of training has been completed.

(Signed) OFFICE OF CIVILIAN DEFENSE.

MEDICAL CORPS

The Emergency Medical Field Units will be identified by a red Caduceus in white triangle set in blue circle.

In the event of a civilian disaster or in a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service, the character and size of which will be established by the local Chief of Emergency Medical Services. Emergency Medical Field units composed of doctors, nurses, and nursing auxiliaries will set up a Casualty Station near the site and give assistance to the injured. Teams of doctors, nurses, and assistants will be dispatched from this station to establish advanced First Aid Posts close to the scene of emergency.

The wearing of this insigne is limited to workers enrolled in the Emergency Medical Service in the *(insert name of city or town) Civilian Defense Organization.*

NURSES' AIDES CORPS

Volunteer Nurses' Aides will be identified by a red cross within white triangle set in blue circle. This indicates that the volunteer has been enrolled and trained by the Red Cross for service in Civilian Defense.

Special training by the Red Cross and by hospitals designated as Training Centers is necessary before women volunteers can serve as Nurses' Aides. Upon the completion of instruction they will become eligible to assist nurses in wards and outpatient clinics of hospitals or in visiting nurse, public health, industrial hygiene, and school health services. The insigne must not be worn until the course has been satisfactorily completed.

The wearing of this insigne is limited to workers who are enrolled in the Volunteer Nurses' Aides Corps in the *(insert name of city or town)* Civilian Defense Organization.

U. S. Army and Navy Procurement and Assignment Service*

(COPY)

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street
Chicago

December 20, 1941.

Dr. George H. Kress
California and Western Medicine
450 Sutter Street
San Francisco, Calif.

Dear Doctor Kress:

I enclose herewith copy of an editorial and an enrolment blank which will be published in The Journal of the American Medical Association for December 27.

It would be highly desirable for you to include a similar blank and the information in this editorial in the next issue of your journal in order that the notice and the blank may come to the attention of as many physicians as possible. By this means it is hoped to create a pool of names from which the Army and Navy may draw in order to provide physicians for the rapid expansion of the armed forces when that occurs.

We will appreciate greatly your cooperation in this regard.

Very truly yours,
MORRIS FISHBEIN.

* For editorial comment and footnote, see page 1.

(REPLY BLANK)

ENROLMENT FORM FOR PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS†

Dr. Sam F. Seeley, Executive Officer
Procurement and Assignment Service
New Social Security Building
4th and C Streets S.W.
Washington, D. C.

Dear Doctor Seeley:

Please enroll my name as a physician ready to give service in the Army or Navy of the United States when needed in the current emergency. I will apply to the Corps Area commander in my area when notified by your office of the desirability of such application.

Signed———————

* * *

1. Give your name in full, including your full middle name:
2. The date of your birth:
3. The place of your birth:
4. Are you married or single?
5. Have you any children? If so, how many?
6. Do you believe yourself to be physically fit and able to meet the physical standards for the Army and Navy Medical Corps?
7. Have you filled out previously the questionnaire sent to all physicians by the American Medical Association?
8. When and where were you graduated in medicine?
9. In what state are you licensed to practice?
10. Do you now hold any position which might be considered essential to the maintenance of the civilian medical needs of your community? If so, state these appointments:
11. Have you previously applied for entry into the Army or Navy Medical Service? If so, state when, where and with what result (if rejected, state why).

Signature———————

Date——————— Address———————

I.*—Letters and Reply Blanks from Committee on Medical Preparedness of California Medical Association: In re "Emergency Field Units"

* Communications having reference serial numbers I to VII deal largely with Emergency Medical and Hospital Services in California, and explain themselves.

CALIFORNIA MEDICAL ASSOCIATION
C. M. A. COMMITTEE ON MEDICAL PREPAREDNESS
San Francisco, December 9, 1941.

The Component County Medical Societies,
Addressed.

Dear Doctors:

This letter is sent to your Society, through your President and Secretary, with request that prompt attenion be given thereto.

1. Enclosed find copy of a telegram received from the United States "Office of Civilian Defense," (Mayor La Guardia of New York, Chairman), through its national medical director, George Baehr, M. D., c/o Office of Civilian Defense, Washington, D. C. In accordance therewith, the Committee on Medical Preparedness of the California Medical Association requests your County Society, through its constituted officers, to promptly contact the hospitals in the area of your County Society, to learn what steps have been taken to date, along the lines indicated in the telegram.

2. For your information, the Bulletins of the Office of Civilian Defense appeared in the "Journal of the American Medical Association," in the following issues:

	Date	*Page*
Bulletin No. 1	August 30, 1941	793
Bulletin No. 2	November 22, 1941	1790

† This is the enrollment blank referred to in the editorial comment, on page 1.

3. Kindly note that the Government requests *Immediate Establishment of Field Units by All Hospitals.*

4. County Medical Societies of the C. M. A., through their officers and committees are requested to *immediately contact all hospitals* in their respective districts in regard to the above.

5. Since it is important to have knowledge in the C. M. A. headquarters office (450 Sutter, San Francisco), of what has been done, *reply blanks for progress reports are enclosed.* (The duplicate copies are for your own files.)

May we hope for reports at your early convenience?

Respectfully submitted,
C. M. A. COMMITTEE ON MEDICAL PREPAREDNESS,
Harold A. Fletcher, *Chairman.*
By George H. Kress, *Association Secretary.*

Attest:
Henry S. Rogers, President
Philip K. Gilman, Council Chairman
Elbridge J. Best, Executive Committee Chairman

Enclosures:
Copy of telegram
Reply blanks
Reply envelope

GHK/s

* * *

Subject: *Telegram from United States Office of Civilian Defense*

Copy of Telegram

1941 December 9 PM 1:46
Mackay Radio

Mrt F81 55 D1 Govt—Ju Washington DC 9 232P

George H. Kress, Secretary-Treasurer
450 Sutter St., San Francisco, Calif.

Office of Civilian Defense requests you to urge all (California) hospitals to establish IMMEDIATELY, emergency medical field units, in accordance with plans outlined in Medical Division Bulletins Number One and Two, and to drill weekly.

Where necessary, reserve field unities should also be organized with medical, nursing and trained volunteer personnel derived from the community.

Urge immediate action.

GEORGE BAEHR, M. D., *Chief Medical Officer,*
Office Civilian Defense, Washington, D. C.

* * *

(REPLY BLANK—RE: HOSPITAL FIELD UNITS)

(Name)———————County Medical Society

California Medical Association

Place ——————— Date ———————

C. M. A. Committee on Medical Preparedness,
Harold A. Fletcher, M. D., Chairman,
Addressed.

Dear Doctor:

1. Herewith is submitted a *Progress Report* concerning the status of Hospital Field Units in the County of (name)———————
2. On, *"Reply Sheet—Names of Hospitals in (name) County,"* we:
   (a) Have given the names of the hospitals in our County.
   (b) Have indicated by check whether they have been contacted.
   (c) Have indicated by word "Yes," if a Field Unit has been organized.
   (d) Have indicated under "Comment and Suggestions," (see below), additional information, (if it is not possible to organize a Field Unit, etc.)
   (e) *Comment and Suggestions:*
   (f) This report is sent to C. M. A. Headquarters, 450 Sutter, San Francisco, by:

Name ———————
Official Position———————

(REPLY SHEET—NAMES OF HOSPITALS IN COUNTY)

Report from the (name)————————County Medical Society, C. M. A.

Herewith, names of hospitals in CITY of (name)———, etc.

Name of Hospital	*Has been Contacted (Check)*	*Has Organized A Field Unit "Yes"*	*Comment*
1.			
2.			
3.			
4.			
5.			
6.			
7.			

This Progress Report, dated————, is sent in by:

Name ————————————————

Official Position————————————————

(COPY)

II.—Letter from California State Council of Defense (Sub-Committee on Health, Bertram P. Brown, M.D., Chairman)

December 12, 1941

IMPORTANT NOTICE

From: Bertram P. Brown, M.D., Chairman Sub-Committee on Health, Committee on Health Welfare and Consumers' Interests, State Defense Council, State of California.

To: California Hospitals

The prompt response of the Association of California Hospitals and the California Medical Association to the appeal for establishment of Emergency Medical Field Units is of great aid in the activities leading to completion of provisions for Emergency Medical Services.

The Emergency Medical Field Unit constitutes a vital portion of the Medical Relief Facilities available for use by a City or County Civilian Defense Council.

The Director of a City or County Civilian Defense Council functioning in any emergency in a Control Center will determine the Emergency Medical Field Units to be placed in actual service and issue instructions upon which they will proceed.

A recognition of the Emergency Medical Field Unit as a component of the Medical Division of a City or County Defense Council is an important step in comprehending important phases of Civilian Defense.

Through complete cooperation with the Medical Division of a City or County Civilian Defense Council, confusion is avoided.

III.—Bulletin from Association of California Hospital to Component Hospital Members

(COPY)

Special Defense Bulletin

ASSOCIATION OF CALIFORNIA HOSPITALS

1182 Market St.

San Francisco, California

December 12, 1941

An Important Message to the Hospitals in the State of California:

To—Complete emergency organization of the hospital for civilian defense purposes—NOW;

Cooperate in emergency medical service plans with local units of: American Red Cross, Civilian Defense Council or Committee, and the City or County Medical Society.

The following important message has been received at this office from the Chief Medical Officer, Office of Civilian Defense, Washington, D. C.

"Office of Civilian Defense requests you urge all hospitals to establish immediately *emergency medical field units* in accordance with plans outlined in medical division bulletins number one and two, and drill weekly. Where necessary, reserve field units should also be organized with medical, nursing and trained volunteer personnel derived from the community. Urge immediate action."

The State Association's Committee on Preparedness, through this headquarters office, especially urges attention to:

The Individual Hospital:

Each hospital superintendent should become thoroughly familiar with the plan of emergency organization with respect to field units and personnel, as outlined in Bulletin No. 1 of the Office of Civilian Defense, published in the Journal of the American Medical Association, August 30, 1941, page 793; and the issue of November 22, 1941, page 1790.

(Before organizing this field unit, confer with the Director of Local Defense, or the Local Defense Authority, which might be one of the following authorities: City or County Office of Civilian Defense, City or County Medical Society, Local Chapter of Red Cross, Local Health Committee of the State Defense Council. *See Notice Attached*).

Read articles on preparedness in hospital magazines. (Bibliography attached.)

Organization of the staff, personnel and facilities of your hospital on an emergency basis, planning optimum bed capacity to handle casualties and evacuees from other areas, or evacuation from your area.

Take precautionary measures for blackouts, according to instructions of local authorities, with special consideration to operating rooms, delivery rooms, night lights, standby emergency lighting plant, and fire prevention.

Each hospital should keep itself informed by keeping in contact with its local hospital conference, and the activities of the local chapter of the Red Cross, Civilian Defense Committee, and the City or County Medical Society, to develop *unity of action, coordination of activities, and prevent duplication of efforts.*

Act independently and immediately in organizing your hospital for the emergency, conferring with other superintendents on such organization, and City or County Medical Society, if necessary.

Each hospital in the state should be thoroughly acquainted with civilian defense plans, transportation service, location of casualty stations and first aid posts, and with the cooperation of the local Red Cross unit the augmentation of nursing services (nurses' aides) and supplies which can be furnished, such as cots, blankets, splints, hot water bottles, etc.

During the emergency, visitors should be requested to visit sick relatives in the hospital during the day time hours.

Your personnel should be kept informed through the departments heads or by bulletin service on preparedness plans within the institution.

Hospitals Collectively:

In the metropolitan areas of Los Angeles County, Alameda County, and San Francisco County, coordination of effort through the local hospital council, which should have representation on the local Emergency Medical Units of the City Civilian Defense Council and Red Cross.

In cities or towns in defense industrial areas where there are two or more hospitals, superintendents should frequently confer with each other on emergency hospitalization plans and have representation on the local Civilian Defense Committees.

Preparedness plans for hospitalization should be discussed at monthly or special meetings of the district Hospital Conferences.

Hospitals in rural areas should be organized on an emergency basis to care for evacuees and casualties from defense areas.

Releases or articles to the Press on preparedness plans of the individual hospital should be considered unethical.

Hospitals in the cities should act collectively through the local defense committee in issuing information on precautionary protection measures or assurances to the public of their utmost cooperation.

Act through the local Hospital Council, District Hospital Conference, Red Cross, or Civilian Defense Committee with respect to the place of the hospital in the local community defense program.

It is suggested that the employees of your hospital should sign up for local civilian defense, with the understanding that each employee in signing the registration card request that he or she be assigned to his or her hospital for emergency service.

Association of California Hospitals:

The headquarters office of the Association (upon request) has advised the Military Authorities—and the State Defense Council has been informed—of the hospitalization facilities in the State of California. Each hospital should be prepared to anticipate calls which may require your institution to accept military and civilian casualties in the event of disaster.

The State Association will keep in close touch with the State Defense Council, American Red Cross, Office of Civilian Defense, and the Military and Naval Authorities, for matters requiring statewide coordination of effort.

Today is the eleventh hour for preparedness organization. Tomorrow may be too late. The hospitals will face a serious situation if not fully organized individually and collectively.

(Signed) ASSOCIATION OF CALIFORNIA HOSPITALS,
Committee on Preparedness,
Ellard L. Slack, *Chairman.*
By Thomas F. Clark,
Executive Secretary.

IV.—Letter Sent to Chairman of Hospital Defense Committees or Key Hospital Executives in Various Defense and Industrial Areas throughout the State

(COPY)

ASSOCIATION OF CALIFORNIA HOSPITALS

December 22, 1941.

To Whom This May Concern:

The headquarters office of the Association of California Hospitals would appreciate, and is in urgent need of, information relating to the coordination of defense hospital facilities in your area, and details covering the organization completed to date for defense purposes in the event of a major disaster, insofar as it relates to hospital service.

This request is approved by Dr. Wallace D. Hunt, Regional Medical Officer, Office of Civilian Defense, and Dr. Bertram P. Brown, Chairman, Subcommittee on Health, State Defense Council, and copy of information collected by this office will be referred to the Office of Civilian Defense and the State Defense Health Committee, which should eliminate any duplication of requests for similar information.

So much has occurred within the past two weeks that it is desirable and necessary that the headquarters office receive the details on the status of preparedness to answer inquiries and to prepare a résumé of organization on a statewide basis so that each of our district units and the state and civil authorities may be informed.

For your reply, the enclosures with this form should include a list of hospitals under your area organization plan and committee organization, bulletins issued, and a list of professional staff.

May I request that you place the headquarters office on your mailing list so that we may receive copies of any bulletins issued by the committee in your area which will keep us informed to date on your activities?

Cordially yours,
(Signed) Thomas F. Clark,
Executive Secretary.

1182 Market Street, San Francisco.

* * *

(REPLY BLANK)

December 22, 1941

To: Association of California Hospitals
1182 Market Street
San Francisco, California

Subject: The coordination of hospital facilities for the emergency in the_____area.

Authority: The name and members of your committee sanctioned authority to coordinate hospital facilities and issue instructions:

*Name of Committee:*_____

Members _____ *Chairman*_____

_____

_____

*Authority Sanctioned By:*_____
(State here name of official agency which authorized the appointment of the committee, i.e. Local Civilian Defense Council, State Defense Council, Red Cross)

Area: _____
(State area covered by your committee, i.e. City or County)

Hospitals: List hospitals under your authority. (Please attach list)

Organization: (A) Enclose plan or program of work undertaken by your committee, and the description of your responsibilities related to (a) receiving casualties and method of distribution of casualties to hospitals in your area; (b) evacuation plan to other areas in event of disaster; (c) instructions issued by your committee to hospitals in your area.

Bulletins: (B) Enclose copy of all bulletins on defense which your committee has issued to the hospitals.

Instructions: (C) Has your committee recommended each hospital:

1. To issue temporary pass or identification card to hospital employees_____(enclose copy)
2. To request employees to register for Civilian Defense and to be assigned to the hospital for volunteer service in an emergency_____.
3. To organize Emergency Field Units in line with Bulletins Nos. 1 and 2, Office of Civilian Defense_____
4. To cooperate with Red Cross in training volunteer nursing aides_____
5. (Other recommendations)_____

Supplies: Has the local Red Cross supplied hospitals with with emergency supplies, including stretchers, blankets, cots, hot water bags, surgical dressings, etc.?_____

Organization With Each Hospital: Have the various hospitals in your area completed this emergency organization covering (a) organization of medical and surgical teams, (b) nursing services, (c) personnel, (d) hospital plant?_____

Professional Staff: Enclose a list of the Medical Staff organized to service medical and surgical teams for emergency defense work in all hospitals in your area.

This report furnished by:

_____
(Name)

_____
(Address)

V.—Letter from California Hospital of Los Angeles to Members of Medical Staff

(COPY)

THE CALIFORNIA HOSPITAL
1414 South Hope Street
Los Angeles, California

December 16th, 1941.

To the Members of the Attending Medical Staff:

Sometime ago the California Hospital Medical Staff, in connection with the Los Angeles Major Disaster Program, formulated a plan in connection with this hospital. This Major Disaster Plan, with some slight changes, is now being accepted under the County organizations for the United States Civilian Defense Program. Briefly, the Civilian Defense Program, from a medical and hospital standpoint, centers around the general hospitals.

The California Hospital will be assigned a certain district which is to be covered should any type of disaster occur. Your Administrative Staff Committee is, therefore, confirming the original program so as to correspond to the National Plan. It is important that you cooperate with us on the following items:

1. Mail the attached questionnaire today. (Mail it whether you will accept an assignment or not as we wish to be able to report to the County Medical Association and the County Civilian Defense with reference to the assignment of each Member of our Staff.)

2. In case of disaster or air raid and you are in the vicinity of the hospital, we suggest that you report to the Staff Lounge Room where further detailed instructions and plans will be given. If unable to get to the hospital, we suggest you contact the County Medical Association.

3. If you contemplate an assignment with this hospital you can secure, now at the Record Room, a temporary Identification Pass Card which will be recognized by the Police until standard identification has been formulated.

Your prompt reply in the enclosed stamped envelope will assist us in this National Defense Program.

Very truly yours,
CALIFORNIA HOSPITAL MEDICAL STAFF,
(Signed) H. D. Van Fleet, M. D., *Chairman.*

* * *

(REPLY BLANK)

For the United States Office of Civilian Defense, I give you the following information:

1. Name _____
2. Office Address _____
3. Office Telephone Number _____
4. Residence Address _____
5. Residence Telephone Number _____
6. I classify myself in the following specialty groups as checked:
   (a) Surgery _____ (If some special branch of surgery, state: _____)
   (b) Medicine _____ (If some special branch of medicine, state: _____)
   (c) Obstetrics _____
   (d) General Practice _____
7. Will you accept an assignment under the Office of Civilian Defense in connection with The California Hospital? State yes or no. _____
8. If not, please state what other assignment you have accepted. _____

Signature of Physician _____

VI.—Letter Concerning Patient's Release for Possible Evacuation from Hospital

(COPY)

THE CALIFORNIA HOSPITAL
Los Angeles, California
December 16, 1941

To the Members of the Attending Staff of the California Hospital:

In cooperation with the Office of the Civilian Defense, the following system has been inaugurated by your Executive Committee for a plan of evacuating patients in case of major disaster or other emergencies, such as air raid, where a large number of people are injured and it is necessary to use the facilities of our acute general hospital for the care of injured people. The plan, therefore, calls for the cooperation of the general physician under the following conditions:

First: All patients admitted will sign a rubber stamp provision stamped on the admitting card, reading as follows:

"In requesting admission to the hospital I agree by my signature on this admission card to being moved to rest home or my home as may be indicated from time to time by my attending physician or the authorities of the hospital should an emergency in the City make this necessary."

Second: From day to day attending physicians should cooperate with the supervisor and the following rubber stamp should be placed on Form MS-80, "Summary of Record," on the day that the patient, in the opinion of the attending physician, could be discharged should an emergency arise:

"This patient is now in condition to be removed from the hospital should an emergency arise. Suggest patient go by:

(Ambulance _____ to (Rest home _____
(Automobile _____ (Home _____
Date _____ Attending Physician _____ M.D."

From day to day this condition of discharge may be altered by the attending physician by changing the method of discharge. The purpose of this stamp is to have available daily a list of all patients who may be discharged so that in case of emergency your Executive Committee may proceed to function on this authority for evacuating patients. We have cautioned all department heads and supervisors in the hospital that this order should be transmitted to the patients in such a way as not to cause any alarm, and it must be understood that it is only to function in case of an extreme emergency when we will operate under the orders of the Office of Civilian Defense.

Thanking you for your cooperation, we are,

Very truly yours,
THE CALIFORNIA HOSPITAL,
(Signed) R. E. Heerman, *Superintendent.*

VII.—Letter Concerning "Volunteer Nurses' Aides"

(COPY)

OFFICE OF CIVILIAN DEFENSE
Washington, D. C.

December 1, 1941.

To: Editors of Medical Journals

From: Dr. George Baehr, Chief Medical Officer, Office of Civilian Defense, Washington, D. C.

The accompanying material is sent to you for your information and for possible mention in your journal. It includes a "Guide for the Training of Volunteer Nurses' Aides" outlining the essential requirements and objectives of this project; the "Syllabus" used in the course; a letter from U. S. Director, F. H. LaGuardia, addressed to hospital executives and directors of schools of nursing; Medical Division Memorandum No. 2 explaining the program further. The release below emphasizes phases of the training program believed to be important to the medical profession.

The national emergency has brought about a shortage of nurses in hospitals, clinics, public health and field nursing agencies. To relieve this situation, which is likely to grow more acute with the expansion of military establishments and of plans for civilian defense, the American National Red Cross and the Office of Civilian Defense have jointly undertaken a project to train volunteer nurses' aides. With such assistance graduate nurses may extend their services to many more persons. The volunteer aides will work under supervision of a nurse and are being trained for certain nontechnical tasks in order that graduate nurses may be released for the highly technical duties they alone are qualified to perform.

The local "Chief of Emergency Medical Service" and the "Local Office of Civilian Defense" in communities where the training program is undertaken have definite responsibilities listed as follows by the national headquarters of the Office of Civilian Defense:

1. To assist the Red Cross and the Civilian Defense Volunteer Office in recruiting and enrolling desirable applicants for training.
2. To assist local chapters to conclude arrangements with appropriate general hospitals to serve as training centers.
3. To assist the Red Cross in organizing and maintaining a placement service so that Volunteer Nurses' Aides may continue to serve and to accumulate experience.
4. To reassign Volunteer Nurses' Aides to emergency duty if the need should arise.

The Red Cross, in collaboration with the Medical Division of the Office of Civilian Defense, has revised its standard course of instruction for Volunteer Nurses' Aides with reference to needs that may develop during the period of the national emergency. The standard course was instituted in July 1940, an outgrowth of volunteer services that have been sponsored by the Red Cross since World War 1. . . .

Authorized duties for the nurses' aides have been outlined in the Red Cross publication "Chapter Organization and Administration of Red Cross Volunteer Nurses' Aides Corps." These duties are of course subject to approval of individual institutions.

In hospitals they may, among other activities, make beds, take care of personal belongings of patients, take care of rubber goods, clean dressing trays, take care of linen closets, feed helpless patients, take patients to and from treatment rooms, help with admission and discharge of patients and care for ambulatory patients. In dispensaries and clinics the aides may serve as interpreters in foreign languages, interpret clinic rules and instructions to patients, help weigh and measure, undress and dress children, assist in taking physicians' notes, help with inventories, clean and put away instruments and help put rooms in order after clinics.

In community health agencies the aides may perform whatever nursing duties are approved by the organization for which they work, provided these duties are performed under the direct supervision of a nurse.

VIII.—Information on Emergency Medical Service

Instructions: Department of Health—City of Los Angeles

Plans for emergency medical and public health services to go into operation in the event of disaster have been formulated by the medical committees of the City and County Defense Councils and the County Medical Association. All hospitals in the area are being contacted for the purpose of establishing a standardized plan for the handling of medical emergencies. The County Medical Society is to act as the clearing house for all calls for medical personnel and all physicians are being circularized to this effect. It is specifically requested, in the event of a disaster, that physicians remain either in their homes or offices and await assignment by either telephone or through radio station KFI which has been designated as the official station for the broadcasting of medical emergency calls.

Numerous reports have been received that physicians experience difficulty in making calls on patients during blackouts. It is therefore requested that

1. Physicians be called only in cases of emergency during blackout period.
2. Calls for physicians be placed early in the day so that patients may be visited prior to the blackout period.
3. Physicians carry with them at all times their State Medical License card or Medical Association card for identification purposes.

December 13, 1941

GEORGE M. UHL, M.D., *Health Officer.*

American Red Cross War Fund Compaign

(COPY)

Western Union
San Francisco, Calif. 9 905P

Dr. Henry S. Rogers, President California Medical Association:—Earnestly request that your organization give full support American Red Cross War Fund Campaign launched December 8th for minimum fifty million dollars. All Red Cross chapters have received their quotas and now busily initiating their local campaigns. Urge you issue statement all your membership that they cooperate with their local Red Cross Chapter by offering their services in campaign in whatever way they can serve best and by making contributions. Kindly send me copy of statement you issue and will give it appropriate publicity.

A. L. SCHAFER, *Manager American Red Cross, Pacific Area, Civic Auditorium, San Francisco.*

* * *

(COPY)

Petaluma, December 10, 1941.

Mr. A. L. Schafer, Manager
American Red Cross, Pacific Area
Civic Auditorium
San Francisco, California.

Dear Mr. Schafer:

Organized medicine as represented in California by the California Medical Association, always has, and in the future will support the American Red Cross.

As individual physicians, and collectively, we will contribute our personal services and money in time of need.

Sincerely yours,
HENRY S. ROGERS, M. D.,
President, California Medical Association.

* * *

(COPY)

AMERICAN RED CROSS
Washington, D. C.

AMERICAN RED CROSS APPEALS FOR $50,000,000 WAR FUND

Calling for the united support of the entire nation the American Red Cross has appealed for a special war fund of $50,000,000 to carry on and expand its work among Army and Navy personnel. The appeal was broadcast to the nation through major radio networks by Red Cross Chairman Norman H. Davis.

In preparation for just such an emergency as the country now faces the Red Cross has been spending funds at the rate of more than $1,000,000 a month. However, with war in the Pacific now a reality the traditional Red Cross responsibilties to the nation and its armed forces have increased manifold and steps were taken immediately to meet these obligations, Chairman Davis said.

"Millions of Americans today desire to demonstrate their will to victory," the Chairman said. "Not all can be in the armed forces, not all can volunteer their services for humanitarian work, but all can volunteer their dollars to arm the Red Cross to be their representative at the scene of battle and distress.

"Today is the day to demonstrate our high morale, our unity, our determination to support our fighting men at the front, and to insure to the wounded and to our

homeless and suffering fellow citizens in our Pacific Islands that we, as a nation, stand one hundred per cent ready to aid them through the Red Cross.

"Let the Red Cross be the spokesman for every community in America. Thus, what we do and what we give will be the triumphant expression of our humanitarian spirit and our faith in victory."

In its months of preparations the various services which the Red Cross provides to the nation and its Army and Navy have been effectively strengthened. But under the new conditions activities all along the line, on the war front and on the home front, must be rapidly expanded. By tradition, custom and Congressional Charter the Red Cross is the organization that maintains those human and family links between our fighting men and the people at home, links which mean so much to both military and civilian morale. Through its ministrations to the men on whose shoulders the safety of our country now rests the Red Cross must prove that they have the wholehearted support of every single American, it was stated. The people, united as always in an hour of peril, will pour from their hearts the means which their Red Cross needs to carry on its work.

Federal Grants for Hospitals and Health Centers: H.R. 4545*

(COPY)

Community Facilities in Defense Areas.—Since the President signed H.R. 4545, on June 28, a bill introduced by Representative Lanham of Texas to authorize an appropriation of $150,000,000 to provide for the acquisition and equipment of public works made necessary by the defense program, the Federal Works Administrator has had for study nearly $800,000,000 of proposals for projects to relieve acute shortages in congested defense areas, projects including schools, waterworks, sewers, sewage, garbage and refuse disposal facilities, public sanitary facilities, water treatment and purification works, hospitals, health clinics and centers, recreational facilities and streets and access roads.

As explained by the Federal Works Agency, this new program was made necessary by the inability of many communities to cope alone with the demand for public works in the face of a phenomenal growth of population due to the expansion of defense industry and enlargement of military reservations and posts. Projects that have been approved will either be constructed by sponsoring municipalities and other agencies with federal financial aid or will be federally financed and constructed. The former are referred to as non-federal projects; the latter, as federal projects.

Field construction divisions have been set up in each of the eleven Defense Public Works Regions to expedite the building of non-federal projects for which grants or loans have been made. In each such Region will be four construction supervisors, one responsible for supervising and following up on the construction of schools, another will handle hospitals, health centers and clinics, a third will expedite water and sewer projects and a fourth will have supervisory jurisdiction over all other types of construction projects.

In the Public Buildings Administration of the Federal Works Agency there has been established an Emergency Operations Unit to supervise and expedite the construction of all schools, health centers and clinics to be built on the basis of 100 per cent federal contributions. With respect to recreational facilities to be wholly constructed by federal funds, this part of the program has been assigned to the War Department.

From time to time the Information Division of the Federal Works Agency has released mimeographed memoranda giving information with respect to the various projects that have been approved for construction. This information has included, in most instances, the type of the project, its proposed location, its sponsor, its estimated cost and the amount of the federal financial contribution and the reasons prompting its approval. Scattered through these memoranda are numerous references to the proposed construction of hospitals, clinics and health centers and the following summary is based on such references found in the available releases:

CALIFORNIA

Salinas.—Additions and alterations to the Monterey County Hospital will be constructed and equipped at an estimated cost of $527,606, all of which will be supplied by the Federal Government. The addition will add 96 beds to the present capacity. Due to the proximity of Fort Ord with 35,000 soldiers, the Salinas Airfield, Kane City Airfield, Camp Roberts and various defense industries, the present population is estimated at 100,000—an increase of 25,000 in one year. Present hospital facilities are considered inadequate. The applicant is the County of Monterey. (Release 208, FWA, October 6, 1941.)

San Luis Obispo.—A health clinic building, including necessary equipment, will be constructed at an estimated cost of $122,477, all of which will be supplied by the Federal Government. The new building will provide quarters for the Department of Health, Welfare Department, a Public Health Laboratory and various clinics. Due to defense activities at nearby Camp San Luis Obispo and Camp Roberts, the city population has had an increase of about 2,000 and the county of about 7,000. The applicant is the County of San Luis Obispo. (Release No. 208, FWA, October 6, 1941.)

Vallejo.—This project calls for the construction of a building to house clinics, public health nursing and milk inspection services, at a total estimated cost of $32,498 to be made available by federal grant. The present city health department is located in an old building, inadequate to house clinics and laboratories. In addition, the area in and around Vallejo has increased to a present estimated population of 44,600 and it is expected the population will reach 61,500 by January 1, 1942. In addition to the Mare Island Navy Yard adjoining the city, the Benicia Army Arsenal is approximately six miles distant. The applicant is the City of Vallejo. (Release No. 158, FWA, September 2, 1941; Release No. 171, FWA, September 9, 1941.)

At the time H.R. 4545 was being considered by the Senate Public Buildings and Grounds Committee, Mr. McNutt in his capacity as Coordinator of Health, Welfare and Related Defense Activities, said that the $150,000,000 appropriation authorized by the bill was a mere "drop in the bucket." Others also voiced the opinion, when the bill was considered in the Senate and in the House, that the sum authorized was inadequate to meet the needs. It was anticipated that further appropriations would be requested to lighten the burden on communities in the vicinity of areas of defense activity.

An additional appropriation of $150,000,000 has now been requested in the form of a bill, H.R. 6135, introduced November 28 by Representative Lanham of Texas. The bill is pending before the House Committee on Public Buildings and Grounds.

Medical Plan Is Organized

An emergency medical plan in the event of attack was placed in effect here today with physicians all over the city standing ready at designated posts to render instant aid.

Under this plan, worked out by the San Francisco County Medical Society, the San Francisco chapter of the American Red Cross, the City and County Department of Public Health and the S. F. Civil Defense Council, citizens are advised, in case of air raid injury, to seek their nearest physician or emergency hospital.

Directions Given

If they are unable to reach these, they are directed to go to one of the 10 medical aid centers; if they cannot reach one of these, or if other facilities are crowded, they are to go to one of the 11 hospital clinics which have established special first aid stations. . . .

* Excerpts from a bulletin issued by the American Medical Association, Bureau of Legal Medicine and Legislation, J. W. Holloway, Jr., Acting Director.

Program Announced

Meanwhile, representatives of all private hospitals in the city, after a meeting with Dr. A. J. Rourke of the Office of Civilian Defense, announced a program.

First, they urged relatives and friends of patients to confine hospital visits to daytime visiting hours. This action was taken to avert possible injury to patients and visitors, as well as interference with hospital personnel, during night blackouts.

Arrangements also were ordered for emergency power supplies in the event existing power systems are damaged, or the master switch for the city pulled to avert disaster.—San Francisco *News*, December 10.

* * *

Hospitals Prepared for Perils of War

Recommendation that relatives and friends confine their hospital visits to daytime hours was made today as San Francisco hospitals went on a war footing.

Plans for evacuation of patients, fire fighting, blackouts and the treatment of large numbers of emergency cases have been adopted and are now in force, following a meeting of all San Francisco hospital administrators under chairmanship of Dr. A. J. Rourke of the Office of Civilian Defense.

Dr. Rourke, who is also administrator of Stanford Hospitals, announced the changes in visiting regulations.

"In order to provide better protection for present patients in hospitals during air raid alarm periods," Dr. Rourke said, "it is recommended that relatives and friends confine their hospital visits to daytime hours."

* * *

Doctors Toil Near Battles

With Furthermost Casualty Clearing Station on Fringe of Libyan Battle field, December 5.—Today I visited the men in white trying desperately to save human lives on the edge of raging battles.

In this North Africa mobile ambulance hospital, the operating theater unit has just completed 106 major operations within 72 hours without losing a single case. The work has been done by two teams working 12 and 16 hours at a stretch and then returning after only two or three hours of sleep.

Doctors in this group avoided making a single amputation among their latest cases, a matter of great gratification to their commanding officer.

The unit was taken as close to the battlefield as possible to avoid carrying casualties in ambulances long distances over rough desert tracks. Much of the equipment used was made in the United States, including the operating theater, x-ray machines and medicines.—San Francisco *News*, December 6.

Navy Relaxes Physical Rules

Washington, December 6 (AP).—The Navy relaxed its physical standards for recruits today in an effort to increase enlistments.

Under a new policy men with certain minor ailments heretofore considered a bar to enlistment will be accepted and, when necessary, the defects will be corrected.

Defects which no longer will disqualify a prospective recruit include varicocele, hydocele, hernia (provided the applicant has an intelligent quotient of 75 or better), nasal deformity, and seasonal hay fever (provided it is not complicated).—San Francisco *Examiner*, December 7.

Evacuation Rules of California Hospital of Los Angeles

THE CALIFORNIA HOSPITAL

December 15th, 1941.

General Order:

TO: Director of Nurses' Office
Admitting Desk
Supervisors

Effective at once, the following order will govern all patients admitted to the hospital, and also applies to patients now in the hospital as far as the supervisors are concerned:

ADMITTING DESK: When patients are admitted special emphasis should be placed upon the rubber stamp imprint, which will be placed on all admitting cards Form MS-1. The rubber stamp reads as follows:

> In requesting admission to the hospital I agree by my signature on this admission card to being moved to rest home or my home as may be indicated from time to time by my attending physician or the authorities of the hospital should an emergency in the City make this necessary.
>
> (Name: Signed)_____

Patients should be cautioned that this is only in case of some extreme emergency, major disaster, or air raid, in which we would have to operate under the Local Director of the Office of Civilian Defense.

SUPERVISORS: The Supervisors should have at their station a rubber stamp as per imprint below:

> This patient is now in condition to be removed from the hospital should an emergency arise.
>
> Suggest patient go by { Ambulance_____ / Automobile_____ }
> to { Rest Home_____ / Home_____ }
>
> Date_____
>
> Attending Physician_____ M.D.

The Supervisors should make a daily check to see that this stamp is placed on Form MS-80, Summary Record on the chart. This stamp is to be placed on the chart when the attending physician is of the opinion that the patient may be discharged in an emergency. From time to time certain rules with reference to this situation will be formulated. At the present time the Committee has ruled on two conditions:

1. All normal obstetrical cases would be in a condition to be discharged six hours after delivery.

2. All fracture cases after cast has set.

The purpose of this order is to have an up-to-date list daily of all cases that may be evacuated should an emergency occur, such as a major disaster or air raid with a large number of casualties where the hospital facilities must be utilized. The supervisor in her daily contacts with the physicians will ascertain when this stamp can be placed on the patient's chart. After the stamp is on the chart it may be modified from day to day as far as the indications by the physicians whether the patient can be discharged by ambulance or automobile to rest home or home. The supervisor's daily report to the Director of Nurses' Office should list these patients separately under these classifications:

1. Patients who can be discharged by ambulance. Under this classification:
   (A) To rest homes
   (B) To homes

2. Those who may be discharged by automobile. Classified:
   (A) To rest homes
   (B) To homes

These reports will be assembled daily in the Director of Nurses' Office so that if an emergency arises, the Administrative Committee can immediately have access to the file for evacuating patients.

(Signed) R. E. HEERMAN, *Superintendent.*
1414 South Hope Street.

Emergency Field Aid and Outpatient First Aid Sets

EMERGENCY FIELD AND OUTPATIENT FIRST AID SETS MADE UP IN CONNECTION WITH EMERGENCY DISASTER SET-UP AT THE CALIFORNIA HOSPITAL,

1414 South Hope Street
Los Angeles

Emergency First Aid Sets for Doctors
(On Squad from Hospital)

Two (2) sets consisting of the following, are prepared:

8 (8 to bag) 3 x 3 gauze sponges
6 2 in. gauze bandages (sterile)
6 3 in. gauze bandages (sterile)
6 large dressings (sterile)
3 dozen safety pins
1 roll ½ in. Z. O. adhesive plaster
1 roll 1 in. Z. O. adhesive plaster
3 doz. cotton wound applicators, sterile.
2 tourniquets
2 oz. Mercurophen Sol. 1/2,000
2 oz. 70% grain alcohol
1 1½ oz. tube Antipyrexol Burn Salve
1 oz. Arom. Spirits of Ammonia
4 amps. Morphine Sulph. gr. ¼
4 1 cc. amps. Adrenalin
4 amps. Caffeine and Sodium Benzoate
1 pair Surgeons Rubber Gloves, size 7½ (sterile)
6 Yucca splints
2 2 cc. Hypo. syringes
2 Hypo. needles, 25 gauge x ⅝ in.
4 Kelly forceps
1 Bandage scissors, 5½ in.
} —Sterile
6 Muslin Binders, ½ yd. x 1½ yd.
6 arm slings
6 ABD pads, small (sterile)

Cardboard splints used by Georgia Street Receiving Hospital, as soon as procurable.

Emergency First Aid Sets for Use in Hospital

Two (2) of these sets, consisting of the following items, are prepared:

4 2 in. gauze bandage
3 3 in. gauze bandage
1 ½ in. roll Z. O. Adhesive Plaster
1 1 in. roll Z. O. Adhesive Plaster
12 2 x 3 Gauze Sponges
2 oz. 70% grain alcohol
1 oz. Tincture of Iodine
½ oz. Arom. Spirits of Ammonia
1 1½ oz. tube Antipyrexol Burn Salve
3 doz. cotton wound applicators 6 in.
1 pair Surgeons Rubber Gloves, size 7½ (sterile)
2 Kelly Forceps (sterile)
1 pair 5½ in. Bandage Scissors (sterile)

Ampoules for restoratives and hypo syringes and needles are already in all floor emergency boxes.

Equipment for Physician's Emergency Kit*

1. (a) *Necessary Equipment*

1 roll sterile folded gauze
2 rolls each of 1-inch, 2-inch and 3-inch gauge bandage
1 roll 3-inch adhesive tape
1 pkg. sterile absorbent cotton
12 applicator sticks and 12 tongue blades
1 thermometer
1 ashlight
1 pair bandage scissors
1 2 cc. Luer syringe, with 2 hypo needles

(b) *Necessary Drugs*

Ointment for dressings—1 oz. pyrol or vaseline
Tincture of merthiolate, 1 oz.
Glycerine and alcohol (equal parts), 4 ozs.
2 adrenalin ampoules
2 ampoules caffeine sodium benzoate
10 tablets pantopon, ⅓ gr. (for hypo or oral use)
1 tube ophthalmic ointment
1 tube tannic acid jelly
6 ozs. ethyl alcohol
2 ozs. aromatic spirits of ammonia

2. *Optional Equipment*

2 ¼ gr. M. S. syrettes
2 ⅓ gr. M. S. syrettes
2 tubes No. 1 plain cat gut
1 needle holder and 2¾-inch half circle needles
Dermal suture material
1 pair curved surgical scissors
2 pairs Kelly hemostats
1 tooth thumb forceps
1 Bard-Parker knife
6 splints (yucca board or heavy cardboard)
1 tourniquet
1 sphygmomanometer

3. *Additional Optional Equipment*

1 ampoule amyl nitrate
2 sterile towels
2 sheets sheet wadding
4 2-oz. rubber-stoppered ampoules sterile water
Mouth gag and airway
Stomach tube
Umbilical tape
½ oz. 1 per cent silver nitrate solution

Press Clippings.—Some news items from the daily press on matters relating to military practice follow:

Promotion Basis Should Be Equal for Military

There has been a great deal of discussion concerning the morale problem of the American army lately. The government has taken steps designed to improve morale, and a Morale Branch, headed by a brigadier general, has been established.

In the Medical Corps, however, the war department has adopted a policy which would seem to be definitely damaging to morale. This policy provides that promotions above the rank of major are suspended so far as reserve officers are concerned. That means that no reserve corps doctor in the country's military services, no matter what his abilities or experience, can advance beyond the grade of major.

The importance of the finest possible kind of medical service in a great army is clear to anyone. Ten thousand physicians now in active service have the job of keeping our soldiers physically and mentally healthy. Only 1,250 of these doctors are regular army men. All the rest have been drawn from the medical reserve.

These reserve officers, in many instances, have given up prosperous practices to enter military service. They are definitely making sacrifices on behalf of their country. And these sacrifices are being made willingly—in any kind of emergency, the doctor is the first to respond. Certainly, it is unfair and unwise to make promotion to high ranks impossible for these men.

Medical reserve officers should be given promotions precisely as are regular army doctors—on the basis of merit, age, etc. It is to be hoped that the War Department changes its policy.—Martinez *Gazette*, November 25.

Student M.D.'s Get Deferment

Washington, December 31 (AP).—Medical students in the last two years of their college courses or in their interneship today were offered commissions in the Army or Navy and the opportunity to complete their education and training.

At the same time Brig. Gen. Lewis B. Hershey, director of Selective Service, said that first and second year students, or even those who only had been enrolled in medical schools would be put in a deferred class "as long as their school officials certify that they give indication they will become qualified medical practitioners."

Third and fourth year students and internes who apply for commissions will be put in a deferred class by local boards.—San Francisco *Examiner*, December 31.

Capacity of Los Angeles General Hospital to Be Increased by 700 Beds

President Signs Bill Appropriating $194,000; Supervisors to Seek Information on Maintenance

An additional 700 beds for the Los Angeles County General Hospital are made available under an appropriation of $194,000 approved recently by President Roosevelt, according to word received from Washington.

The appropriation is one of 21 totaling $3,886,000 of the $150,000,000 recently allocated by Congress to the Defense Public Works Agency for health and welfare activities among defense workers and their families.

The Federal government will install the 700 beds at the General Hospital, where there is plenty of vacant space.

Estimates of county officials are that it will cost $1,000,000 annually to maintain the equipment.

An application has been filed by the county government for an appropriation to cover the maintenance costs and word is now being awaited as to whether the President's approval of the equipment appropriation also covers the application for maintenance costs.

The total bed capacity of the General Hospital is 4374. There are now 2600 beds in use.—Los Angeles *Times*, December 24.

American Physicians Ready to Meet Wartime Diseases

Chicago, Dec. 18 (INS)—Fortified by new scientific knowledge and new medical methods, America's 185,000 licensed physicians today were being placed on a full wartime footing to combat modern war's companion killer, disease.

More than 10,000 U. S. physicians have already been called up for military duty, at a rate of six for each 1000 troops, and the number mobilized for front line service will be steadily expanded. Those remaining behind, meanwhile, face increasing civilian tasks.

Against influenza, which in 1918-19 caused an estimated 21,000,000 deaths including 1,075,685 in North America, medical science this time enters the lists with weapons and knowledge far superior to those available in the last war.

The influenza virus was isolated for the first time in recent years. An influenza vaccine, consisting of anti-bodies developed in chickens infected with the virus, has been produced. It is expected that the vaccine will be brought into wide use if danger of an epidemic appears.

However, Dr. Morris Fishbein warned today against over-optimism with regard to wartime health. Dr. Fishbein who is editor of the American Medical Journal published in Chicago by the American Medical Association, declared:

"We are much better prepared than ever before to fight epidemics, and we are taking every conceivable step to prevent them. But we can't say that epidemics, which have been sweeping the earth for centuries, won't occur again."

Even age-old bubonic plague still presents a serious preventive problem, he pointed out. The government is spending more than $1,000,000 to stamp out traces of this, and the even more deadly pneumonia plague, which were found in rats and ground squirrels on the Pacific Coast recently.

Dr. Fishbein, serving on a dozen national committees and commissions and consulting with scores of other groups, is a key figure in the nationwide network of organizations set up in the last year and a half to direct wartime medical work.—Burlingame *Advance*, December 18.

* The equipment articles here given were listed in "The Bulletin of the San Francisco County Medical Society," January, 1942; Vol. XV, No. 1.

Men Over 35 May Never Be Drafted

Washington, December 14 (AP).—War Department officials made clear today that it would be a long time—perhaps never—before any men outside the 21-35 age group are drafted for the army despite the proposal to require all aged 18 to 64, inclusive, to register.

Brigadier General Lewis B. Hershey, Selective Service director, warning against any "hysteria," in connection with the draft extension, said there was no way of telling when it might be necessary to tap the reservoir of men outside the 21-35 group.

"We can meet the situation today and tomorrow with the present draft age limits of 21 to 35," Hershey said.

Secretary of War Stimson requested Congress last week to enact legislation for the registration of all men from 18 to 64, inclusive, and making those from 19 to 44, inclusive, subject to military training and service. This registration, Hershey said, would apply to 41,000,000 men including the 17,500,000 who already have registered.

But the program as of today, Hershey explained, calls for the induction of the remaining 1,000,000 in the 21 to 27 age brackets; then eligibles in the group from 28 to 35, will be called up, and next the 1,000,000 who become 21 each year.

"Having done that, you ought to have a full year's supply of men," Hershey said.

In the meantime, there will be a continuing re-examination of men deferred because of dependency, employment in vital defense industries and minor physical disabilities.

"We must go at this thing, calmly and coolly," Hershey said. "We must not take every man regardless of his physical condition or no matter how many dependents he has."

One of his aides said that employers should start thinking about replacing young men now deferred with older men and perhaps women.—San Francisco *Chronicle*, December 15.

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Draftees Needed

[*Estimate on December 3, 1941; before War Started*]

Only 200,000 draftees are likely to be called in the next seven months. The Army now has 1,600,000 men, and plans to have 1,800,000 by next June 30.

About 200,000 more are likely to be drafted in the ensuing six months beginning July 1, if the international status quo continues. Present appropriations call for an Army of 2,000,000 men a year, from now. Equipment for an Army of 3,200,000 is to be accumulated under proposed appropriations (including the new $7,000,000,000 bill). But the additional men above 2,000,000 are not likely to be brought in unless all out war starts.—San Francisco *Examiner*, December 3.

* * *

Medical Unit of California State Guard

Taking enlistment facilities right to the potential candidates, members of the State Guard's First Medical and Ambulance Battalion yesterday recruited men and women at a sidewalk station at Sixth and Springs Sts.

Lieut. Brandon Bernstein was in charge of the station yesterday. Other officers, including the group's commander, Maj. Frank G. Nolan, will be on hand during a month-long campaign.

Presenting information to questioners as well as signing up recruits were Corp. Oldean Rhodine and Mittie M. Barham, members of the nurses' corps, which is part of the unit.—Los Angeles *Times*, December 2.

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Doctors on Alert

San Francisco's doctors and nurses have come through.

While some other groups met this week's emergency with a welter of inefficiency, with plans that were only on paper, with brilliant ideas and nothing else, the men in white and their teams stood ready.

Last night, they stood ready to man their posts with personnel and equipment intact.

On Tuesday night, while others awaited a blackout, they were already at their jobs.

And when the blackout came yesterday morning, they were back again—ready for what might come.

Tuesday night and early yesterday morning, this writer toured a dozen medical aid stations set up in every district in San Francisco. They were ready—had been ready for hours.

Doctors and nurses were there, equipment was sorted and in place, emergency assistants, drivers, first-aid helpers, Boy Scout orderlies, Red Cross workers were all in position. They weren't merely waiting to be called. They were there.

Telephone lines—special trunks to the Red Cross, to the blood bank, to other medical centers—were installed and operating.

The same picture was found at emergency hospitals and special clinics of most general hospitals.

At the San Francisco County Hospital, the Laguna Honda Home and the Hassler Health Farm, entire wards had been cleared and made ready to receive bomb raid victims. Patients were moved to lower floors, sand piles were put on the roofs for protection against incendiary bombs.

Every hospital could swing into blackout operation in a few seconds. Windows were already covered, emergency generators could supply electricity, and water supplies and fire fighting equipment was at hand.

City Health Officer Geiger reported about 30 emergency field units were ready for action in any bombed area.

The medical aid stations—11 are now in readiness, with others organized to take over in case any station is bombed—may be one of the most vital features in this organization. One is located in Grace Cathedral, the others are placed in schools.

Each can be expanded from an emergency station into a field hospital.

Each station, organized around three doctors and three trained nurses, can operate on a 24-hour basis. Each is equipped to dress wounds, provide blood transfusions, repair broken bones, and even perform emergency operations.

Planned on paper years ago—planned to handle any emergency from earthquake, fire and epidemic to outright enemy attack—planned in spit of ridicule and scoffing, the medical defense of San Francisco has faced its greatest challenge—and has not been found wanting.—San Francisco *Chronicle*, December 11.

* * *

Los Angeles Blackouts

U.S.C. Professor Reports Los Angeles Darker in First Attempt Than Rome

Los Angeles' first blackout, incomplete though it was, proved to be as successful as those in Italy after a year's subjection to R.A.F. bombings.

Dr. Ivan Benson, professor of journalism at the University of Southern California, made this observation last night. And his opinion merits more attention than the average, because he spent a full year under European blackouts.

Studied in Sweden

Studying in Stockholm while on sabbatical leave, Dr. Benson was trapped there by the outbreak of the war and it wasn't until June, 1940, that he was able to leave, traveling by train through Germany and Italy en route to the ship which carried him and his family of four back to the United States.

From his experience, Stockholm's blackouts were by far the most complete he had seen, with those in Germany and particularly those in Berlin—although they had been bombed on numerous occasions—only a little better than our initial ones.

Italy Inefficient

Italy, although it had had a year's practice, was very inefficient in darkening its cities," he said.

"Authorities were very strict in Stockholm during blackouts, allowing not even a pencilpoint of light to escape from houses. Under no circumstances were the people allowed to light cigarettes or pipes out of doors," Dr. Benson said.

"We used 'blackout paper' to cover the windows, paper black on one side and green on the other. Autoists did not paint their headlights blue but masked them, except for a small slit which directed the light downward.

Pedestrians' Buttons

"Pedestrians wore phosphorescent buttons on their clothes to warn motorists, who drove slowly and carefully. The accident rate, incidentally, in Stockholm was very, very low during blackouts."

The Swedish city also had the same trouble at first that Los Angeles experienced, a failure of many citizens to hear siren warnings. This was soon remedied, Dr. Benson said, by distributing sirens, one for each small area, with a designated person in charge.—Los Angeles *Times*.

* * *

Air Raid Rules

These are the official air raid warning signals which have been adopted for San Francisco and the eight counties bordering San Francisco bay.

No "alert" will be sounded. Instead, a signal—designed for uniformity throughout the eight counties—will be given for immediate, simultaneous blackout.

The Blackout Signal: Fluctuating siren and whistle blasts of two minutes' duration. The blackout signal will rise and fall in tone. Watch the street lights.

For All Clear: A continuous signal of two minutes' duration at a steady pitch. Watch the street lights.

In San Francisco, the siren blasts will be sounded by the Ferry building siren and by all police and fire apparatus in the city.

What to Do

1—Turn out all house lights if you have not blacked out your windows. Stay home. When bombs fall, lie down on the floor away from the path of flying glass.

2—If you are driving, pull car into curb, turn out lights and get under cover and lie down. Avoid crowded places and stay off the streets.

3—If incendiary bombs fall on your house, cover them with dry sand. Keep sand bags in your home. If possible keep garden hose attached to faucet. Play a *fine spray only* on bombs. *A jet* or *splash* of water will make them explode.

4—If you have a soda-and-acid extinguisher (the kind you use upside down), put your finger over the nozzle to make spray. Don't use the small cylinders of liquid on bombs. They are all right for ordinary fires.

5—Under raid conditions, fill your bathtub and all buckets for Fire Department in case water mains are broken. Locate your nearest fire alarm box now and use it instead of a telephone.

6—If gas is used, go to the most inside room of your house (fewest doors and windows). Paste paper over windows, stuff cracks in doors and windows with rags.

7—Appoint one member of the house now as air raid warden to take charge and remember all the rules.

8—Above all, be calm. Stay home. The enemy wants you to create a panic and rush into the streets and highways. Don't do it. Safety lies in taking proper shelter and combating incendiary bombs correctly. Keep blacked out until the all clear.

* * *

Women Doctors Make Military Service Bid

Appeal Made for Admission to Army and Navy Reserve Corps on Same Basis as Men

Philadelphia, December 6 (AP).—Directors of the American Medical Women's Association sent resolutions to President Roosevelt today asking that women doctors be admitted to the Army and Navy Reserve Corps on the same basis as men.

Although the Army does not specifically ban women doctors, the Navy does, and there are no women members of either reserve, directors point out at a meeting here.

The resolutions request that women physicians be taken into the Army Reserve "on the same terms as other members" and "with all the privileges accorded thereto" and that "all proper and necessary steps be taken" to make them eligible for the Navy Reserve.

Copies were sent to military officials and United States Surgeon General Thomas Parran. . . . —Los Angeles *Times*, December 7.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

C.M.A. Refresher Courses in Obstetrics and Dermatology

The Committee on Postgraduate Activities has issued a memorandum from which the following is taken. Members of component county societies who would be interested in such work are requested to contact promptly their officers and postgraduate committees in order that suitable schedules may be arranged.

* * *

(COPY)

In addition to informative circulars already mailed to county societies by the C. M. A. Committee, (containing names of physicians who have indicated willingness to give postgraduate talks on topics under which their names appear), the Committee on Postgraduate Activities presents this memorandum concerning two full-time representatives of the California State Board of Public Health, whose services are now available for postgraduate conferences and refresher courses.

Appended hereto, are brief biographical sketches of Doctors Sydney E. Sinclair and Julius R. Scholtz, of the California State Board of Public Health. Doctor Sinclair is particularly interested in pediatrics, and Doctor Scholtz in syphilology and dermatology. They will be happy to discuss any phases of the specialties in which they are particularly interested. Some of their talks are illustrated by slides, in case you have facilities for the display of same.

In addition to talks that may be given in the evening, say between 8:00 and 10:00 P.M., Doctors Scholtz and Sinclair are prepared to place themselves at the service of members of your Society in consultation work, or in special round-table conferences during the afternoon.

There will be no charges for this consultation service, and you are asked to feel free to avail yourselves of this offer, in any problem or other cases concerning which you would be glad to have their opinions. This service is available to any of your members.

If, for a refresher program, you wish to utilize the services of Doctors Sinclair and Scholtz, may we ask that you forward your requests to the undersigned as promptly as possible, in order that schedules may be prepared that will not conflict?

Please feel free to communicate with us in regard to the above, or on any other postgraduate programs. Awaiting your advices,

Cordially yours,

C.M.A. COMMITTEE ON POSTGRADUATE ACTIVITIES,
DWIGHT L. WILBUR, M. D., *Chairman.*
(Signed) GEORGE H. KRESS, M. D., *Secretary.*

* * *

Sydney E. Sinclair, M.D.—Graduate of the University of Pennsylvania Medical School, 1936; at Henry Ford Hospital, Detroit, 1936-1938; On Pediatric Service, New Haven Hospital, 1938-1940; Instructor in Pediatrics, Yale University School of Medicine, 1940-1941; Pediatrics Consultant, Bureau of Child Hygiene, State Department of Public Health, 1941.

Doctor Sinclair is prepared to speak on the general field of pediatrics and most specified problems of broad interest. The following are examples of subjects which might be of interest: "Recent Advances in Pediatrics"; "Use of Sulfonamides in Pediatrics"; "Immunization Procedures"; "Care of Premature Infant".

* * *

Julius R. Scholtz, M.D.—Graduate of the Stanford Medical School, 1934; Resident Dermatologist and Syphilologist, Los Angeles County Hospital, 1934-1936; Instructor in Medicine (Syphilology), University of Southern California Medical School, 1936-1940; Consultant Syphilologist, Bureau of Veneral Diseases, State Department of Public Health, 1941.

Doctor Scholtz will be happy to discuss any topic or subjects for which request is made.

Both speakers will present material either formally or informally. Slides are available on most subjects if desired.

Research Study Club of Los Angeles

Announcement of two courses: (a) Clinical, in Eye, Ear, Nose and Throat, and (b) Cadaver, in Head and Neck. Courses begin on January 19th and 22nd.

* * *

The Research Study Club of Los Angeles has announced its Eleventh Annual Mid-Winter Postgraduate Clinical Course in Ophthalmology and Otolaryngology to be held January 19th to January 30th, 1942, inclusive. This year there will also be a Special Course, "Applied Anatomy and Cadaver Surgery of the Head and Neck," January 22 to January 28, 1942, inclusive, this arrangement being made so that the Cadaver Course will not interfere with the regular Clinical Course.

Following the John Finch Barnhill tradition, the Research Study Club of Los Angeles announces a special course in "Applied Anatomy and Cadaver Surgery of the Head and Neck." This course will be given during the Eleventh Annual Mid-Winter Postgraduate Clinical Course. It will be given by Simon Jesberg, M.D., and Professor S. A. Crooks, anatomist.

Dr. Crooks, professor of Anatomy at Loma Linda University, who is so highly regarded for the clarity of his teaching, will demonstrate all anatomic relations in the different fields of head and neck operations so that

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

these relations will be clear in the mind of each man while performing his work under the direction of Dr. Jesberg, who will demonstrate the different operations in these regions.

This Cadaver Course will be given during the two weeks of the Mid-Winter Clinical Course, beginning on January 22nd, at hours which will not conflict with the didactic lectures or the regular work of the Clinical Course. Twenty cadavers are available. The Course is restricted to 40 members—two to each table. The fee is $50.00. In order to register for this Special Course, kindly send $25.00 to Pierre Viole, M.D., 1930 Wilshire Blvd., Los Angeles, and pay the other $25.00 at the opening of the Course. Naturally the members will be enrolled in the order of registration. In the future it may be possible to have a larger group, but this year only 40 members will be provided for, in the Cadaver Course.

The Eleventh Annual Mid-Winter Postgraduate Clinical Course will be given from January 19th to January 30th, inclusive. The first week will be devoted largely to the Eye; the second largely to the Ear, Nose and Throat.

Guest speakers will be Ralph I. Lloyd, M.D., of Brooklyn, who will carry the main burden of the Eye course; and John R. Lindsay, M.D., of Chicago, who will be the principal teacher of the Ear, Nose and Throat.

Dr. Bennet M. Allen, for so many years Professor of Biology at the University of California, Los Angeles, will present "Modern Concepts of Endocrine Therapy." Dr. Allen is a pioneer in this field, and originated one of the first formal courses in endocrinology in this country.

Clinton H. Thienes, M.D., Professor of Pharmacology of the University of Southern California, School of Medicine, will bring an up-to-the-minute therapeutic evaluation of the drugs of the sulfonamide group; epinephrine; and anesthesia, local and general.

Dr. Orda A. Plunkett, for sixteen years in the Department of Botany of the University of California, Los Angeles, will present the subject of the role of pathogenic fungi and molds in diseases of the eye, ear, nose and throat.

The fee for the Clinical Course is $50.00; the fee for the Cadaver Surgery Course is $50.00; for those who take both, the fee for the two courses is $100.00. Kindly send a deposit of one-half of the fee to Pierre Viole, M.D., 1930 Wilshire Blvd., Los Angeles, and pay the balance at the opening of the Course. It will be advisable to write for accommodations direct to Mr. Nickerson, Manager, Elks Club, Westlake Park, Los Angeles, who will arrange to accommodate as many as possible in the Elks Club itself and the others in adjacent hotels and apartment houses.

All those who are in active Military Service may enroll at one-half of the regular fee, for either the Clinical or the Cadaver Course—or both.

Courses for General Practitioners: In Los Angeles

The School of Medicine College of Medical Evangelists, at the White Memorial Hospital, has announced Winter Session courses in January, February, and March, 1942.

Application should be made as early as possible since enrollment in all courses, unless otherwise stated, will be limited to 20 doctors. A check for tuition should accompany the application. Make checks payable to Postgraduate School, College of Medical Evangelists.

For further particulars and application for courses, address G. Mosser Taylor, M.D., Chairman, Committee on Postgraduate Education, 312 North Boyle Avenue, Los Angeles. For telephone communications, call Mrs. Esther Varney, ANgelus 8221, Station 297.

OUTLINE OF COURSES

CARDIOLOGY — 12 hours, $24.00

Tuesdays, 8:00 p.m., Evans Hall, Clinic Building.
Course begins Tuesday, January 6.
The fundamentals of cardiac diagnosis and treatment will be reviewed by means of lectures, round table discussion and presentation of patients. Topics for discussion are as follows:

Pathological Physiology in Heart Disease - - - - - - - W. E. Macpherson, M.D.
Cardiac Drugs - - - - - - - - F. G. Moor, M.D.
Radiological Examination of the Heart W. L. Stilson, M.D.
Electrocardiography - - - W. P. Thompson, M.D.
Cardiac Arrhythmias - - - - - D. E. Griggs, M.D.
Hypertensive Vascular Disease and Subacute Bacterial Endocarditis - R. M. Tandowsky, M.D.
Rheumatic Fever and Chronic Rheumatic Heart Disease - - - - - - R. M. Clarke, M.D.
Syphilitic Heart Disease and The Heart in Myxedema and Thyrotoxicosis - - - - - - R. M. Tandowsky, M.D.
Heart Disease in Pregnancy and The Surgical Risk in Cardiac Patients J. F. Anderson, M.D.
Coronary Artery Disease
(a) Angina Pectoris
(b) Acute Coronary Occlusion - D. E. Griggs, M.D.
Congested Heart Failure - - W. P. Thompson, M.D.
Neuro-circulatory Asthenia Pericarditis R. M. Clarke, M.D.

GASTRO-ENTEROLOGY — 12 hours, $24.00

Tuesdays, 8:00 p.m., Junior Amphitheater, Service Building.
Course begins Tuesday, January 6.
Diseases of the gastrointestinal tract will include: Peptic ulcer and its complications; new growths of the gastrointestinal tract; gastritis and gastroscopy; diarrhea and constipation; liver disease together with physiology and functional tests; gall bladder and pancreatic disease; esophageal lesions and esophagoscopy. This work will be based in the main on clinical presentations, case studies, demonstrations and round table discussions.
Drs. Eugene L. Armstrong, James Cryst, Olov A. Blomquist, Otto Arndal, I. Lew Mintz, Clarence E. Stafford, Eugene J. Joergenson, H. James Hara, Walter L. Stilson.

NEUROLOGY — 10 hours, $20.00

Wednesdays, 8:00 p.m., Evans Hall, Clinic Building.
Course begins Wednesday, January 7.
Organic lesions of the central and peripheral nervous system will be covered didactically, illustrated by gross specimens, clinics, and blackboard outlines. The topic for lectures will be:
(a) The Essentials of a Neurologic History and Examination.
(b) The Apoplexies—Their Diagnosis and Treatment.
(c) Craniocerebral Injuries—Management of Cases.
(d) Multiple Sclerosis—An Important Neurologic Disease in the Young Adult.
(e) The Sciaticas—Their Differential Diagnosis.
(f) Headaches.
(g) Pituitary Diseases and their Diagnosis.
(h) Diseases of the Spinal Cord and Peripheral Pain.
Dr. Cyril Courville.

MINOR ORTHOPEDIC SURGERY (Limited to 10 doctors) — 8 hours, $16.00

Wednesdays, 8:00 p.m., Room 215 Clinic Building.
Course begins Wednesday, February 2.
Subjects covered in this course will be those in which the general practitioner should have working knowledge, such as low back pain, arch strain, surgery of the hand and foot, besides the common lesions affecting the major joints of the extremities—shoulder, elbow, hip, and knee.
Drs. Jos. C. Risser, G. Mosser Taylor, C. Cornell McReynolds, Fred Polesky.

GENERAL UROLOGY — 6 hours, $12.00

Wednesdays 8:00 p.m., Junior Amphitheater, Service Building.
Course begins Wednesday, January 7.
Didactic lectures including lantern slides, motion pictures and patient demonstrations. Topics for discussion are:

(a) Gonocecal Infection in the Male.
(b) Treatment of Non-specific Urethritis and Prostatitis and Stricture.
(c) Toxic Hyperplasia of the Prostate.
(d) Disturbance of Sexual Function.
(e) Acute Urinary Retention—Courses and Treatment.
(f) Pathological Conditions of the Prostate.
(g) Urinary Infections in the Female.

Drs. Hermon C. Bumpus and Roger Barnes.

PROCTOLOGY (Limited to 10 doctors) 20 hours, $40.00

Mondays and Thursdays, 7:00-9:00 p.m., Evans Hall, and Room 205
Clinic Building, and Operating Rooms in Hospital.
Course begins Monday, January 5.

The diagnosis and treatment of the diseases of the anorectal region is an important subject. Although the anatomical field is small, mild complaints may be associated with serious disease. In this course a review will be given of the common lesions of the large bowel, rectum and anal canal. Diagnosis and treatment will be stressed, including the technic of examination, office methods of treatment, and operative technic.

Dr. R. Malcolm Hill and Staff.

VARICOSE VEINS (Limited to 10 doctors) 6 hours, $12.00

Thursdays, 8:00 p.m., Evans Hall, Clinic Building.
Course begins Thursday, January 8.

An intensive course with modern treatment of varicose veins and ulcers of the leg will be presented. Pathological anatomy and physiology will be the introduction for the discussion of the diagnostic tests and later the treatment by injection and operative methods. The instruction will include the use of the Varicose Veins Clinic for one session on Wednesday, January 21, from 1:00 to 3:00 p.m.

Drs. Carl H. Talmadge, Alfred E. Gilbert, John M. Fernald.

ANESTHESIOLOGY

Thursdays, 8:00 p.m., Evans Hall, Clinic Building.
Course begins Thursday, February 5.

Round table discussions and demonstrations in Anesthesiology will be presented, emphasizing the pitfalls and how to avoid them. Inhalation, spinal, regional, rectal, and intravenous anesthesias as well as combined types will all be covered.

Drs. Lawrence Lee and Dirk E. Stegeman

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative Petitions

Progress on the proposed Basic Science Initiative Law has been a little slower recently, with the bulk of petition forms from the metropolitan centers already in and those from other counties coming along in a steady flow. Volunteer signature solicitors from various counties have been asked to take on additional petitions at this time, and circulators have also gone to work in fields allied with medicine and dentistry.

About one-third of the required signatures have already been secured. This means that a long road lies ahead before the total number of names is on hand for filing with the Secretary of State.

More volunteers are needed. Any member or anyone affiliated with a member is urged to take on the responsibility of securing another 100 names on a petition blank. Send in your request for a new blank to the Public Health League in Los Angeles or San Francisco, or to the C. M. A. office, 450 Sutter, San Francisco.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M.D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

(COPY)

THE PUBLIC HEALTH LEAGUE OF CALIFORNIA
Organized to Protect the Public Health by the Preservation of Modern, Scientific Medicine, Dentistry and Nursing
244 Kearny Street
San Francisco, California

December 10, 1941.

Dear Doctor:

Concerning the Basic Science Initiative Campaign:

One man in Southern California has turned in over 800 signatures. Several members have filled two or more petitions. But too many have failed to do their share. Public reaction to the initiative has been splendid. Those who have filled their petitions report that it was not a difficult task. All that is required is a little real application of effort.

Any registered voter in your County can circulate a petition in that County. If you feel that you cannot personally do this little job, here are some methods that have proved successful.

1. Your Secretary can circulate a petition if she is a registered voter.
2. Your druggist friend can circulate one if he is a registered voter. He should be willing to assist you in this.
3. Any patient or other friend who is a registered voter can circulate a petition.
4. Some members have employed a registered voter to circulate a petition.

Any method you may wish to use is satisfactory if the petition is circulated and sworn to by a registered voter in your County.

Fraternally yours,

(Signed) SIDNEY J. SHIPMAN, M.D., *President.*
(Signed) FRANCIS ROCHEX, M.D., *Secretary, Northern District.*

COMMITTEE ON MEDICAL DEFENSE

Malpractice Coverage: A New Company Enters California

Good news for all California physicians was contained in information received last month that another American insurance company had re-entered the field of malpractice insurance in this state. Full terms of the new domestic malpractice policies are not yet known, but policy limits offered in California will be $50,000 for any one injured person and $150 000 for any one policy year. Policies will be offered only in counties where the underwriter is assured of the cooperation of an active and effective medical defense committee.

County medical societies which have not already organized an active medical defense committee will doubtless want to do so in the near future, in order that the new policies may be obtained by their members. County society by-law amendments setting up such a committee have already been suggested in a "Brochure on Medical Defense" issued by the C. M. A. Committee on Public Relations in 1940 and distributed to county societies this year by the Committee on Medical Defense.

It is the present hope of the Committee on Medical Defense that the entrance of a domestic insurance carrier into the California malpractice field will bring the advantages of competition and a subsequent reduction in malpractice insurance rates.

Any questions on this new development may be addressed to the C. M. A. Committee on Medical Defense, Nelson J. Howard, M. D., Chairman, at the C. M. A. office, 450 Sutter Street, San Francisco.

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

Medical Schools Speed Courses

Year Cut Off Training to Provide More Doctors in War

Dr. Willard C. Rappleye, an officer of the Association of American Medical Colleges, on December 19th, announced the adoption of a plan by the Association to lop a year off the regular four year course, in seventy-six recognized schools to provide more physicians in war time.

He pointed out, in response to inquiries, that the plan was not binding on the schools—all members of the association—although he expressed belief they would adopt it generally.

"No medical school has to adopt this plan," he said. "The executive council of the Association voted for the change and it is the spokesman for the Association."

Doctor Rappleye, New York city commissioner of hospitals, estimated that 5,000 more physicians would be graduated in the next three years than heretofore if the plan was adopted generally.

The plan calls for first-year medical students to begin their courses about July 1 of next year, instead of in September and October. Vacations will be cut to a minimum, so that the colleges will operate on a twelve month calendar year.

"Under the plan," Doctor Rappleye said, "there will be no reduction in the standards of instruction or the content of the medical course, but the four-year program will be condensed into approximately three calendar years.

"The acceleration of the medical course will help to provide more physicians during the next few years for the military and civilian needs."

* * *

More Frequent Examinations by State Board of Medical Examiners

Dwight W. Stephenson, State director of professional and vocational standards, on December 17th, ordered professional, examining boards under his jurisdiction to speed up their tests for physicians, dentists and others engaged in similar work.

Stephenson said his action was taken to increase the trained professionals available for wartime work.

Most of the boards formerly delayed license examinations until at least 100 applications had been received. Under the new order, they will give tests for twenty-five applicants.

C.M.A. CANCER COMMISSION†

Wars, Traffic Accidents, and Cancer

In considering the subject of war, it is interesting to compare the deaths from wars, traffic accidents, and cancer, for a fifteen-year period in the United States. The United States has fought six major wars since 1776. These six wars covered a total period of fifteen years—the Revolutionary War, War of 1812, War with Mexico, Civil War, War with Spain, and the first World War. According to Livingston and Pack, 244,357 American soldiers were killed in action or died during these fifteen years of war. The fatalities due to traffic injuries are well known. Every year, the Fourth of July is marred by many hundreds of accidents. The slogan, "Worse than War" has been logically adopted in the fight to control traffic accidents because during the fifteen-year period from 1922 to 1937, 441,912 people were killed during the time when this country was free of combat and at peace.

It is difficult to turn to a subject which justly deserves the same consideration as the mobilization of our youth and national resources for a war against aggression. A critical examination of the facts will reveal that the world cannot enjoy real security until the threat of the rising cancer death rate has been removed. Cancer causes 150,000 deaths in the United States each year, and during the past fifteen years, 2,250,000 individuals have died of cancer.

Deaths in the United States

15 years of war	244,357
15 years of traffic accidents	441,912
15 years of cancer	2,250,000

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County (1)

Josephine Borson, *Berkeley*

Butte-Glenn County (1)

Edward Evan Simpson, *Oroville*

Kings County (1)

Thomas Troupe Messenger, *Avenal*

Orange County (1)

Arthur T. Harris, *Laguna Beach*

Sacramento County (7)

Marshall R. Beard, *Sacramento*
James E. Conklin, *Sacramento*
James E. Culleton, *Sacramento*
Miriam Hubbell, *Fair Oaks*
Arthur C. Huntley, *Sacramento*
Kenneth M. Johnson, *Sacramento*
Raymond J. Simmonds, *Sacramento*

San Francisco County (4)

Bert Lewis Halter, *San Francisco*
Douglas M. Kelley, *San Francisco*
Frederick J. Northway, *San Francisco*
Robert N. Shaffer, *San Francisco*

Sonoma County (2)

Harding Clegg, *Santa Rosa*
Horace F. Sharrocks, *Santa Rosa*

Stanislaus County (1)

Archie N. Tonge, *Modesto*

Transfers (3)

Harold J. Chapman, from Los Angeles County to San Diego County.

Daniel M. Clark, from Santa Barbara County to Ventura County.

W. A. Vinks, from Placer-Nevada-Sierra County to Sacramento County.

† For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Barrette, Louis Charles. Died at Sacramento, November 15, 1941, age 45. Graduate of Washington University School of Medicine, St. Louis, Missouri, 1925. Licensed in California in 1927. Doctor Barrette was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✤

Chapman, Joseph Andrew. Died at Bakersfield, November 16, 1941, age 43. Graduate of University of Texas Faculty of Medicine, Galveston, Texas, 1924. Licensed in California in 1926. Doctor Chapman was a member of the Kern County Medical Society, the California Medical Association, and the American Medical Association.

✤

Christian, James Tilden. Died at Sacramento, November 30, 1941, age 62. Graduate of Cooper Medical College, San Francisco, 1902. Licensed in California in 1902. Doctor Christian was a member of the Sacramento Society for Medical Improvement, the California Medical Association, and the American Medical Association.

✤

Gilbert, Quinter Olen. Died at Oakland, December 3, 1941, age 58. Graduate of University of Michigan Medical School, Ann Arbor, Michigan, 1914. Licensed in California in 1920. Doctor Gilbert was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

Kilgore, Eugene Sterling. Died at San Francisco, January 2, 1942, age 64. Graduate of Harvard Medical School, Boston, 1909. Licensed in California in 1911. Doctor Kilgore was a member of the San Francisco County Medical Society, the California Medical Association and a Fellow of the American Medical Association.

✤

La Fontaine, Emma Caroline. Died at San Francisco, November 14, 1941, age 77. Graduate of Cooper Medical College, San Francisco, 1887. Licensed in California in 1888. Doctor La Fontaine was a retired member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

✤

Priestley, Spurgeon Floyd. Died at Stockton, November 23, 1941, age 73. Graduate of the Barnes Medical College, St. Louis, Missouri, 1898. Licensed in California in 1901. Doctor Priestley was a retired member of the San Joaquin County Medical Society, the California Medical Association, and the American Medical Association.

✤

Stadtmuller, Ellen Smith. Died at San Francisco, November 25, 1941, age 58. Graduate of the University of California Medical School, Berkeley-San Francisco 1912. Licensed in California in 1912. Doctor Stadtmuller was a member of the San Francisco County Medical Society, the California Medical Association, and the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

News Items

The Alameda County Auxiliary has planned its January meeting to honor Mrs. Harry O. Hund, President of the State Auxiliary. Her message will make the Auxiliary more aware of its responsibilities.

The program is to be a musical one, furnished by two of the Alameda Auxiliary members: Mrs. Frederic M. Loomis, who has been giving a number of concerts for the British War Relief, will sing the vocal numbers; and Mrs. James L. MacDonald, one of the younger members and a graduate of the Chicago Institute of Music, will play selections for the piano.

Seventy Auxiliary members have enrolled for a First Aid course with the Red Cross.

The campaign for *Hygeia* is well on its way. Every member has been contacted and offered the Christmas rate.

* * *

The Contra Costa Auxiliary held its first meeting of the season at the home of Mrs. U. S. Abbott. Mr. J. C. Wampler, Curator of the Archeological Museum of the Pacific School of Religion, discussed "Palestine—Modern and Ancient."

The first autumn luncheon was enjoyed at Tisbury-Farm, north of Walnut Creek. It was well attended by both Contra Costa and Alameda County members, including Mrs. Hobart Rogers, past State President; Mrs. R. Stanley Kneeshaw, present State Chairman of Membership; Mrs. R. Abbott Crum, Alameda County President; and Mrs. George A. Gray, President of Santa Clara County Auxiliary.

Dr. Robert J. P. Harmon, President of Contra Costa Medical Association, gave a short address.

* * *

Humboldt County Auxiliary held its third meeting of the season at the home of Mrs. Walter Dolfini.

As many of the members knitted, it was decided that the Christmas party for Mrs. Alice Osborn's girls, the T. S. L. Club, (which was mentioned in the last report,) be given at "Snug Harbor", the country home of Dr. and Mrs. John M. Chain, Sr. It was also arranged that each girl be given a gift, and a committee was appointed to purchase these gifts.

The question of having a lecture on the "Control of Cancer" at a future meeting was discussed.

* * *

On November seventh, Fresno County Auxiliary had a very successful Bridge-Benefit for its philanthropic fund, at the Sunnyside Country Club. Over two hundred attended, and it was agreed to make this affair an annual event, since it was such a social and financial success.

The regular December meeting was held at the University Sequoia Club, twenty members attending. Captain Samuel C. Ross spoke on "Health Measures at the Air Base in Fresno," and Dr. Henry Randall held a brief discussion on the proposed Basic Science Law.

* * *

The Los Angeles County Auxiliary met for a Thanksgiving luncheon on November twenty-fifth, in the Los Angeles Athletic Club. There were seventy-five members present.

Mrs. Lyman Johnson spoke of "Red Cross Service in Our Emergency", explaining the nine different divisions of Red Cross work in which women may take part and do their bit in this present emergency.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Mr. Basil Rice spoke on "Civilian Defense", and gave some interesting highlights of the plans being worked out for defending the immediate locality in case of attack.

* * *

Members of the Monterey County Auxiliary met for luncheon and their regular business meeting on November sixth, at the Santa Lucia Inn. The Hollister members were in charge of the meeting and presented a very interesting program. Mrs. Young, of Hollister, reviewed an article from *Hygeia* and Chaplain Albert S. Click, of Fort Ord, spoke on "Patriotism and Religion."

Following a business meeting, the members and their guests adjourned to the El Sausal Sanatorium, where Mrs. Sam Black, (who is in charge of occupational therapy among the tubercular patients,) told the women of her work among the patients, and showed a very interesting display of handwork. Dr. John Sharp and Miss June Guthrie conducted the Auxiliary members through the Sanatorium.

* * *

The Orange County Auxiliary has had two meetings this year. The first was a Bridge Tea held at the home of Mrs. J. W. Truxaw, of Anaheim. The second meeting was held at the home of Mrs. J. C. Kraushaar. This was a joint meeting with the Orange County Dental Auxiliary. Mrs. Laura Warren, Executive Secretary of the local Red Cross, gave a talk on the activities of her organization.

Tea was served with the two presidents of the Auxiliaries, Mrs. J. B. Price and Mrs. Stanley Norton, at the tables.

* * *

The December meeting of the Santa Clara County Auxiliary was turned into a "new-member tea", and was held at the San Jose Country Club. Those attending were greeted by the President, Mrs. George Gray, and Mrs. R. Stanley Kneeshaw, First Vice-President of the State Auxiliary, and all past County Presidents, in order. About one hundred members and guests were served.

Members of the Santa Cruz and Monterey County Auxiliaries were also present. Wives of the County Hospital doctors and Agnew State staffs were invited, as well as the wives of the physicians of Moffatt Field Army Base.

A string quartet furnished the music throughout the afternoon, and Christmas decorations and candles made the clubhouse a beautiful setting for the occasion.

* * *

The Santa Barbara Auxiliary held its regular luncheon meeting at the El Mirasol Hotel on November seventh. About fifty members were present and the meeting was planned to honor Mrs. Harry O. Hund, who was unable to attend. Mrs. R. Stanley Kneeshaw substituted and was a most interesting guest of honor. She entertained with highlights concerning the State Organization and the work of various county units.

A large number of new members were introduced, along with others from the Hoff General Hospital.

The Auxiliary sponsored a Bridge Tea given by the Girl Scouts and is very busy each Monday with the Women's Volunteer Service, making bandages constituting the chief activity in this line.

* * *

San Diego County Auxiliary held its annual benefit Bridge-Dessert, to raise funds for the group's expanded Service program. The party was held at the Thursday Clubhouse and was limited to sixty-five tables.

Boxes of home-made candy and hand-made bridge scores were sold during the afternoon.

The Auxiliary's benevolences include this year contributions to local health agencies: Community Chest, Visiting Nurses, Tuberculosis Association; The Women's Field Army, Crippled Children's Society; gifts to the Vauclain Home children's ward; and the maintenance of the annual scholarship for a premedical student recommended by San Diego State College.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,071
November 31, 1941	32,966

California Physicians' Service is owned by its beneficiary and professional membership. The professional membership constitutes the electorate and, by process of vote, controls policy and management. This is achieved through the election of Administrative Members.

For the purpose of adequate and complete representation from the professional membership the State has been divided into twenty-one districts. Each district elects two Administrative Members who hold staggered terms of three years. In addition, there are a limited number of Administrative Members-at-large elected by the Administrative Members themselves.

The Administrative Members meet once a year in connection with the annual meeting of the California Medical Association for the purpose of reviewing the affairs of C.P.S. and electing, from the membership, persons to fill vacancies which may have occurred on the Board of Trustees. The Board of Trustees is the governing body of C.P.S. It holds regular meetings every two months to determine policy and to consider problems in adminstration.

Election of Administrative Members from districts has just been completed. There was an excellent response from the professional membership throughout the State Each district had to fill a vacancy through the expiration of a regular term. Some districts had two vacancies, due to the failure to elect an Administrative Member at the last regular election. Results were as follows:

District I.—(San Francisco, San Mateo and Marin Counties)
Three Year Term: T. Henshaw Kelly, M. D.

District II.—(Part of Los Angeles County)
Three Year Term: Carl R. Howson, M. D.

District III.—(Alameda and Contra Costa Counties)
Three Year Term: Dexter N. Richards, M. D.

District IV.—(Part of Los Angeles County)
No nominations.
Three Year Term: Lewis P. Bolander, M. D., incumbent.
Two Year Term: John J. Smith, M. D., incumbent.

District V.—(Santa Clara and Santa Cruz Counties)
Three Year Term: Leslie B. Magoon, M. D.

District VI.—(Part of Los Angeles County)
Three Year Term: William Gibbs, M. D.

District VII.—(Lake, Mendocino, Napa, Solano, and Sonoma Counties)
Three Year Term: Henry S. Rogers, M. D.

District VIII.—(Part of Los Angeles County)
Three Year Term: Kenneth C. Brandenburg, M. D.

District IX.—(Del Norte and Humboldt Counties)
Three Year Term, Allan R. Watson, M. D.
Two Year Term: Joseph S. Woolford, M. D.

District X.—(Orange County)
Three Year Term: B. J. Van Doren, M. D.
Two Year Term: No nominations—Glenn C. Curtis, M. D., incumbent.

District XI.—(Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono and Tulare Counties)
Three Year Term: Clinton D. Collins, M. D.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

District XII.—(San Luis Obispo, Santa Barbara and Ventura Counties)
Three Year Term: P. A. Gray, M. D.
Two Year Term: Hugh F. Freidell, M. D.
District XIII.—(Alpine, Amador, Calaveras, San Joaquin, Stanislaus and Tuolumne Counties)
Three Year Term: J. Frank Doughty, M. D.
District XIV.—(Imperial and San Diego Counties)
Three Year Term: Lyell C. Kinney, M. D.
Two Year Term: William A. Clarke, M. D.
District XV.—(El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter and Yuba Counties)
Three Year Term: Frederick Scatena, M. D.
Two Year Term: Louis E. Jones, M. D.
District XVI.—(Kern County)
Three Year Term: William H. Moore, M. D.
District XVII.—(Butte, Colusa, Glenn and Yolo Counties)
Three Year Term: Leslie Freudenthal, M. D.
Two Year Term: Willard W. Carey, M. D.
District XVIII.—(Riverside and San Bernardino Counties)
Three Year Term: No nominations—Carlos Hilliard, M. D., incumbent.
Two Year Term: C. L. Emmons, M. D.
District XIX.—(Shasta, Siskiyou, Tehama and Trinity Counties)
Three Year Term: O. T. Wood, M. D.
Two Year Term: O. J. Hansen, M. D.
District XX.—(Monterey and San Benito Counties)
No nominations.
Three Year Term: J. B. McCarthy, M. D., incumbent.
Two Year Term: L. P. Davlin, M. D., incumbent.
District XXI.—(Lassen, Modoc and Plumas Counties)
Three Year Term: C. I. Burnett, M. D.
Two Year Term: W. B. McKnight, M. D.

MEDICAL EPONYM

Howell-Jolly Bodies

In an article entitled "The Life-History of the Formed Elements of the Blood, Especially the Red Blood Corpuscles" and published in the *Journal of Morphology* (4:57-116, 1890), William Henry Howell (b. 1860), professor of physiology and histology, University of Michigan, described these as follows:

> I have met with corpuscles containing granulations very frequently. . . . Sometimes the granules—which stain, by the way, like nuclear chromatin—are so arranged as to represent the outline of the nucleus. . . . There is no evidence to show that the granules are the last remaining fragments of an absorbed nucleus. . . . They must be looked upon, it seems to me, as bits of the nuclear chromatin (membrane) left behind when the nucleus leaves the cell.

J. Jolly, in a monograph entitled "Recherches sur la formation des globules rouges des mammifères [Studies in the Formation of Red Cells in Mammals]," which was published in the *Archives d'Anatomie Microscopique* (9:133-314, 1907), repeatedly refers to similar bodies.—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Lane's Kink

W. Arbuthnot Lane (b. 1856), surgeon to Guy's Hospital, London, first described this condition in an article, entitled "Chronic Constipation: A consideration of its surgical treatment," which appeared in *Surgery, Gynecology and Obstetrics* (6:115-129, 1908).

> . . . . There can be no doubt that the pathological changes which are present in these conditions of imperfect drainage are most obvious and important. . . . The portion of the caecum above the brim of the pelvis, together with the ascending colon, is retained in a position of abnormal fixity to the posterior wall of the abdomen. This is affected [*sic*] by the development of adhesions between the outer aspect of the large bowel and the peritoneum covering the abdominal wall in its vicinity. . . . As a rule these adhesions merely fix the bowel, but occasionally they constrict its lumen very materially in one or more situations and render it liable to become obstructed. Not only do the adhesions anchor this part of the large bowel, but they also bind down to the iliac fossa a proportion of the appendix. . . . The result of this arrangement is that, when the caecum is loaded, it exerts a vertical strain upon the proximal portion of the appendix and causes that structure to become flexed abruptly at the lower limit of its adhesions. . . . When I recognize that the mechanics of the intestines have been altered to a degree that cannot be rectified satisfactorily by the division of bands, etc., I divide the ileum at a distance of about five or six inches from the caecum, . . . the descending colon and sigmoid are removed, the rectum . . . being occluded in the same manner as the ileum.—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Eck's Fistula

Nikolai Vladimirovich Eck (b. 1849) of St. Petersburg (now Leningrad), published a "preliminary communication" in the *Voyenno-Meditsinsky Jurnal* (130:1, 1877) entitled "K voprosu o perevyazkie vorotuoi veni [Ligature of the Portal Vein]." A portion of the translation follows:

> If in the dog, after establishing a free communication between the inferior vena cava and the portal vein, one ties off the portal vein, the change in direction of the blood flow and the deprivation of the liver of blood from the portal vein produce no serious results in the organism. The animal recovers from the operation, his nutrition improves after recovery, and he remains in perfect condition.

The technic of the operation is described and its possible application to the treatment of human ascites mentioned.

The medium by which this experimental procedure attained its first wide publicity was an article entitled "Die Eck'sche Fistel zwischen der unteren Hohlvene und der Pfortader und ihre Folgen für den Organismus [Eck's Fistula between the Inferior Vena Cava and the Portal Vein and Its Results upon the Organism]" by Hahn, Massen, Nencki and Pavlov, which appeared in the *Archiv für Experimentelle Pathologie und Pharmakologie* (32:161-210, 1893).—R. W. B., in *New England Journal of Medicine.*

Postgraduate Courses in Obstetrics

At the Chicago & Lying-In Hospital the Department of Obstetrics and Gynecology of the University of Chicago will offer five postgraduate courses in obstetrics between January 12 and June 6, 1942. In view of the present national defense program in all probability many physicians will be forced to take on heavier loads in those communities where some of their colleagues have gone into government service. This will mean that some of these men who have done little or no obstetrics lately or who are poorly trained in obstetrics will be called upon to do more in this field just as in other fields. It seems especially appropriate that refresher and postgraduate courses should be made available to all physicians in order that our civilian population may continue to have the same good medical service that the profession wants them to have. The physicians may contribute in the national defense programs by maintaining good local morale and doing the type of practice the laity expects of them at home.

The courses are sponsored by the Illinois State Department of Health and the Children's Bureau of the U. S. Department of Labor. The features of the program consist of observations on current managements of normal and abnormal states of the pregnant, parturient, and puerperal patient. Lectures, demonstrations, clinics, and other teaching means augment the operating room and birth room observations, and ward round discourses. The course is run on a non-profit basis. A deposit of $25.00 is required on registration. $10.00 of which is refunded at the completion of the course. All the members of the department participate in giving the courses. Additional information and application blanks may be obtained by request from *Postgraduate Course, Department of Obstetrics and Gynecology, 5848 Drexel Avenue, Chicago, Illinois.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10 and 11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

American Medical Association Broadcasts.—*Doctors at Work,* the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company went on the air for its second season, beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; *2:30 to 3:30 p. m., Pacific Standard time.*) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

Medical Broadcasts*

Los Angeles County Medical Association:

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of January, 1942:

Saturday, January 3—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, January 3—KFI, 9:45 a.m., The Road of Health.
Saturday, January 10—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, January 10—KFI, 9:45 a.m., The Road of Health.
Saturday, January 17—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, January 17—KFI, 9:45 a.m., The Road of Health.
Saturday, January 24—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, January 24—KFI, 9:45 a.m., The Road of Health.
Saturday, January 31—KFAC, 8:45 a.m., Your Doctor and You.
Saturday, January 31—KFI, 9:45 a.m., The Road of Health.

Physicians' Automobile Emblems.—Automobile emblems for physicians' cars, designed in accordance with regulations of the State Department of Motor Vehicles, are now under production in both San Francisco and Los Angeles. These emblems are the only ones recognized by the State Highway Patrol as official for exemption of physicians from strict interpretation of state speed laws if the physician is answering a bona fide emergency call.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Inquiry about the emblems may be made of the State Department of Motor Vehicles, Sacramento, or of Irvine & Jachens, 1068 Mission St., San Francisco, or American-Pacific Stamp Co., 918 S. Main St., Los Angeles.

Health as a Factor in Nation's Defense.*—A nation of strong, healthy people is a nation that has met the most primary and fundamental requirement of national defense.

Brigadier General Lewis B. Hershey, deputy director of the selective service machinery, says this nation must be more concerned with its health, and especially with the health of its young people.

He points to the serious fact that out of 1,000,000 examined for selective service, 380,000 have been rejected for physical deficiencies.

In a nation supposed to have the most modern and widespread medical facilities, this record is more than a little shocking. It is something of which we can be ashamed.

Of the 390,000 young men rejected from the first million men examined, approximately 130,000 were rejected because of troubles arising out of nutritional deficiencies. They had either been eating the wrong things most of their lives, or not enough of the right things.

The National Youth Administration, reporting on the physical condition of young people employed in its special training programs, says that nine out of every ten of them are suffering from health defects of some kind.

The American Medical Association, analyzing these records of health deficiency among millions of young Americans, says most of the defects can be remedied; that they are acquired, not hereditary.

That at least is hopeful.

Health is a basic national asset, important in peace time as well as in war time.

Right now, while the nation is still technically at peace, unsatisfactory health conditions, low resistance to infections and disease, are hampering the gigantic industrial armament effort.

Paul V. McNutt, administrator of the federal security system, pointed out the other day that "health, not strikes, is the real bottleneck in the defense program."

He pointed out further that strikes and lockouts were the cause of only two per cent of time lost in industry in the last year.

Sickness represented nearly 90 per cent of the normal working time lost in the last year.

The social security estimates place the toll of sickness at approximately 400,000,000 working days lost in the last year. This is the equivalent of the full-time normal services of about 1,100,000 workers annually.

The tremendous economic loss caused by poor health, and the gains that would be inherent in better health, can be understood in the light of these illuminating figures.

These are rather gloomy figures. They show a national health record that is not too good, that has room for great improvement.

Here are some brighter figures, reminding us that the United States, even with its discouraging record of sickness and physical deficiencies, is probably among the healthier nations of the world.

Americans have the best longevity record; the American baby born in 1941 has a life expectancy of more than 65 years.

The American maternity death rate record, which a few years ago was a national disgrace, has been cut in half since 1935.

In the last year such diseases as tuberculosis, pneumonia, diphtheria, appendicitis and scarlet fever have killed fewer persons per 100,000 of population in the United States than ever before in history.

The bad health record of which General Hershey complains so bitterly is not the fault of the medical profession in America. It is the fault of individual carelessness, ignorance, and lack of public health measures. These faults can be corrected, and if the defense crisis forces their correction, that will have been a very great gain.

Medicine in Early California Crude.—The advance of medicine during the past few decades seems almost miraculous when the careers of doctors of less than two centuries ago are studied.

So writes Frances Tomlinson Gardner, assistant in the library of the University of California Medical School, in an article in the current issue of the Annals of Medical History. The article is about Pedro Prat, a surgeon on the Spanish ship San Carlos sent from Mexico in 1769 to help establish the first colonies in California.

By the standards of his time, Prat was a good doctor, yet he was almost helpless in his attempts to attend to the needs of the scurvy-ridden crew of the ship San Carlos as it made its way to California.

Mrs. Gardner describes some of the attempts of Prat to help the crew as follows:

"He stirred the staggering survivors into using boiling vinegar to wash down the inside of the ship. He fumigated with everything he could find: brimstone, asafetida, some condemned tobacco he found, a barrel of pitch, and even flashed gunpowder moistened with vinegar hoping that the explosion would jar loose the infectious matter from the timbers.

"All this sounds absurd, and was, yet it must be remembered in deference to Prat and other eighteenth century sea-surgeons whose ability seems completely lacking, that conditions on dry land were hardly any better. This was the age of darkness in the progress of medicine when the processes of disease were unhampered by intelligent treatment and physicians were grouping in an abyss of conflicts and misinformation."

Only a few of the crew died during the voyage, but after the arrival of the ship at San Diego only a few could move about, and many died in an improvised hospital tent. The same conditions existed when Prat went with a party to Monterey, but in spite of handicaps the California colonies were established.

The Hidden Asset: "Services Donated by Physicians."—Leafing through a hospital report, physicians must sometimes make wry faces as they read in the list of "items received," such donations as "One Hundred dollars from John Smith" or "Flowers for the Solarium from Mary Brown." The wry faces are not due to any objection to the publicizing of such donations; but rather because the greatest contribution the hospital ever receives is somehow not listed in the "income" side of the hospital ledger. The greatest gift, of course, is the personal professional services of the medical staff given as a free contribution to ward and clinic patients. It would be a refreshing experience to see some hospital soberly list in its column of donations an acknowledgment such as "Services in clinic rendered by Dr. Black conservatively estimated at $1500" or "Ward operations performed by Dr. Jones valued at least at $10,000."

* Editorial in Oakland *Post-Enquirer*.

The services of the doctor are unconsciously or consciously omitted in hospital bookkeeping statements and hospital publicity. To be sure, in some reports a footnote announces that "The Board is grateful to the members of the medical staff for its cooperation" or something like that. But nowhere does it appear that the services of these doctors represent the paramount donation, equivalent to about 86 per cent of the gross hospital income. Indeed, the fallacy of so-called "free services" is carefully maintained. The doctors work gratis, therefore the work is given "free" to the patient and the cost need not appear in the hospital books. In a larger sense, of course, there are no "free" services. Even the water you get for your radiator in a service station is not really "free". It is an expense item, just as is the printing cost on a "free booklet" you receive through the mail. Someone pays for it.

So with "free medical services". The doctor "donates" or "gives" the service just as surely as the Ladies' Guild "gives" the flowers for the solarium, or just as surely as the other contributing patrons give cash to the hospital's endowment fund.

The services of the medical staff constitute a huge hidden asset not appearing in the hospital's books. How huge, any doctor can roughly calculate by finding the average clinic patient-load; the daily average ward census; and allowing a reasonable fee for the medical attendance, compute the dollars-and-cents value of the services rendered by the staff. Incidentally, the ordinary layman too often firmly believes that doctors *are* paid by the hospital for working in wards and clinics, and assumes thus that the medical profession is the beneficiary of taxed funds or private welfare contributions. The enlightenment of the public on this point would appear to be the job of the hospital authorities and Organized Medicine.

In our thinking and talking about the distribution of medical care, would it not be better—and more accurate—if we doctors, at least, abandoned the phrase "free medical services" and replaced it with "services donated by physicians"? At least some light would thus be thrown on this important hidden asset of the hospital.

Doctor's Urged for Coroners.†—Doctors, attorneys and judges of Santa Barbara county discussed ways and means of improving coroner and public administrator services in Santa Barbara county and throughout California, at a dinner meeting and a lecture in Bissell hall at the Cottage hospital this week.

The meeting was arranged by Dr. Lawrence F. Eder, program chairman and president-elect of the County Medical Association. The speaker was Dr. Jesse L. Carr of the University of California and medical examiner for the San Francisco coroner's office.

The point made by Dr. Eder in his introduction of Dr. Carr, and by Dr. Carr, was that the elected laymen coroners cannot give the public protection against crime and against situations and disease dangers that might present their first evidences at the coroner's office.

"There are at least 15 ways in which murder can be committed without detection by the ordinary coroner's service," Dr. Carr told his audience. With pictures and skulls Dr. Carr illustrated a number of cases in which murder had been detected where accident or suicide, on the surface, appeared to be the cause of death.

Dr. Eder and other members of the county medical association who expressed their views on the subject said that the public should have the protection of trained service of a specially-trained physician in determining causes of death when such causes are not reported by adequately informed attending physicians.

The representatives of the law at the meetings were consulted about ways and means of changing the coroner laws of California and also concerning the advisability of having an attorney appointed as public administrator instead of using an elected layman.

† Item in Santa Barbara *News*, December 10.

Sixth National Social Hygiene Day: February 4, 1942.— Sixth National Social Hygiene Day, one of America's leading public health events, will be observed on Wednesday, February 4, 1942, according to Dr. Walter Clarke, executive director, American Social Hygiene Association.

Calling Attention to: Pharmacological items of potential interest to clinicians. Happy New Year! Make it so in responsible performance of scientific work!

1. *From those for whose international behavior we assume responsibility:* K. Mori and S. Morigami find liver and millet-feeding inhibits chemical carcinogenesis (Gann, 35: 86,121, 1941). E. Sal (Jap. Med. Sci., Pharmacol., 14: 1,31, 1941) shows low dosage x-ray radiation of adrenalon and tyramine intensifies hyperglycemic action, while high intensity diminishes it. 183 pharmacological reports published in Japan in 1940; abstracted in above.

2. *War items:* C. W. Glover, *Civil Defense*, Chemical Pub. Co., Brooklyn, 1941, costs $16.50,—but may be worth it. Same company has issued *Planned Air Raid Precautions*. Consult May, 1941, *Calling Attention To* for bibliography on Chemical Warfare. K. L. Pickrell reports that daily spraying of burns with 3 per cent sulfadiazine in 8 per cent triethanolamine is very effective and without toxic reactions; also suggests ointment of 5 per cent sulfadiazine and 8 per cent triethanolamine in stearin (Bull. J. Hopkins Hosp., 69: 217, 1941).

3. *Notes on Cancer:* M. B. Shimkin discusses toxic and carcinogenic effects of stilbestrol, and finds no carcinogenic activity of desoxycorticosterone (J. Nat. Cancer Inst., 2: 55,61, 1941). L. T. Larinow of Leningrad indicates that primary change caused by carcinogens is alteration in protein metabolism (Cancer Res., 1: 860, 1941). A. Lasnitski and A. K. Brewer in K^{39}/K^{41} ratio in sarcoma (ibid. p. 776).

4. *Notes from Nature:* J. B. S. Haldane surveys human life and death at high pressures (Nature, 148: 458, 1941). Extraordinary discussion provoked by C. H. Waddington's "Relations between Science and Ethics" (ibid., pp. 270, 342, 411, 533). C. B. Fawcett's *Bases of a World Commonwealth* (London, 1941) is reviewed by R. Brightman, who notes that they are same in principle as C. Streit's *(Union Now)*, L. Curtius's *(Decision)* and J. Huxley's *(Democracy Marches)*, and that tendency toward international community of ideals and interests is more significant than the particular form that community may take. (ibid., p. 515).

5. *Notes on vitamins:* C. T. Javert and C. Macri (Am. J. Obs. Gyn., 42: 409, 1941) show that daily ingestion of mineral oil reduces blood prothrombin probably by preventing absorption of K vitamins. K. Hofman, D. B. Melville and V. duVigneaud (J. Biol. Chem., 141: 207, 1941) show biotin to be a carboxylic acid with N-N' cyclic urea and thio ether radicals. E. E. Snell (ibid., p. 121) finds a dihydroxy dimethyl-butyryl derivative of taurine inhibits growth of all organisms requiring performed pantothenic acid.

6. *Odds and Ends:* Neat reports on absorption, distribution and excretion of P^{32} by J. H. Lawrence, L. A. Erf and L. W. Tuttle (J. Clin. Invest., 20: 567, 1941). They find leucemic patients retain more than normals and with evidence of effectiveness (Ann. Int. Med., 15: 487, 1941). D. M. Dixon and L. H. Douglass (Bull. School Med. Univ. Maryland, 26; 139, 1941) show pentobarbital and paraldehyde significantly reduce fetal and maternal distress, duration of labor, and operative interference in delivery. R. D. Hotchkiss and R. J. DuBos report isolation of gramacidin as high MW polypeptid with no free amino groups; confirmed by H. N. Christensen, M. Tishler et al (J. Biol. Chem., 141: 155,187,197, 1941). B. Woolf (Proc. Roy. Soc., B, 130: 60, 1941) shows that specificity of type II pneumococcus antiserum for the type polysaccharide is due to glucuronic acid. K. M. Bowman and E. M. Jellinek review alcoholic mental disorders (Quart. J. Stud. Alc., 2: 312, 1941). A. Gorbman covers comparative anatomy and physiology of anterior pituitary (Quart. Rev. Biol., 16: 294, 1941).

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Says Socialized Medicine Soon a Certainty

Before the emergency is over the United States will have "socialized medicine."

So predicted Dr. Russell C. McCaughan, executive director of the American Osteopathic Association, when he arrived here yesterday to prepare for a national convention next summer.

"The bill is already written—the Epstein bill—and is almost certain to pass the House within the next few months," he said.

He estimated that the measure, which requires those earning $3000 a year or less to take out compulsory health insurance, which would cost at least 6 per cent of salary.

All but the most expensive hospitals will come under the jurisdiction of the state's medical program, Dr. McCaughan said.

Methods of paying doctors have not been worked out but under the terms of the act, everyone will be allowed a choice of his own doctor.

Dr. McCaughan will be in Los Angeles five days, staying at the Biltmore.

He will confer with Dr. W. Ballentine Henley, president of the College of Osteopathic Physicians and Surgeons.—Los Angeles *News*, December 5.

* * *

New USC Medical Dean Appointed

Los Angeles, December 20 (AP).—President Rufus B. von KleinSmid of the University of Southern California announced today the appointment today of Dr. Seeley G. Mudd of Los Angeles as dean of the school of medicine.

Doctor Mudd, long prominent in medical circles here, succeeds the late Dr. Paul S. McKibben, who died November 11.

* * *

Governor Olson Names Members of "Youth Correction Authority"

California took initial steps yesterday to put into operation her new youth correction authority law designed to provide a more progressive treatment of youthful delinquents.

Governor Olson named O. H. Close, Waterman, Amador County; Karl W. Holton, chief probation officer of Los Angeles County, and Harold Slane, deputy City Attorney of Los Angeles, as the three members of the California Youth Correction Authority. . . . —San Francisco *Chronicle*, December 13.

* * *

State Safety Council Names New Directors

Los Angeles, November 26 (CNS).—Twelve new directors were in office today for the next year, as the California Safety Council began its eighth year of activities.

Named for 1942 were, Dr. Samuel B. Norris, dean of the Stanford University School of Engineering; Lester G. Bradley, San Diego publisher; Dr. John C. Irwin, Los Angeles; Superior Judge William R. McKay, Los Angeles.

James Rolph III, San Francisco insurance broker; Dr. Elliott A. Rouff, San Jose; John E. Carroll, Los Angeles Truck Company official; Dr. Charles A. Dukes, Oakland, past president of the *California Medical Association*. . . . —Long Beach *Sun*, November 27.

* * *

Rodent Plague

A warning that the United States may have a plague epidemic to combat is issued by the American Medical Association through an editorial in its journal. While typhus is being held in check only with the greatest difficulty in Europe and may have reached epidemic proportions in Poland and the Balkans, the AMA pronouncement declares that "no doubt plague, as far as this country is concerned, is a problem of greater potentiality."

Plague is present on the Pacific Coast, not as human cases, but in fleas of rats, ground squirrels, and marmots. From these sources it is feared that the dreaded disease can spread to cause an epidemic in human beings when conditions become suitable. Long-continued and careful plague control, involving rat-proofing of buildings, trapping, poisoning and examinations of dead rodents, must be practiced in any area in which plague has appeared.

The consequences may be tragic, the AMA warns, if there is not a careful integration of the plague control activities of cities, counties, states and the federal government, with the use of trained personnel and the appropriation of adequate funds. The four horsemen of the apocalypse—war, hunger, disease and death—travel with the increased speed of mechanized transportation, it is pointed out. Sudden and widespread outbreaks of disease arising from hidden infections are more likely than ever. The insulation of this country from the disease consequences of war will prove a colossal task and will require the most careful planning and effort.—Lodi *Times*, December 3.

* * *

Free Medical Care

For some years the National Medical Association of New Zealand has been waging a pitched battle with the Government on the socialization of medicine. Undeterred by a threatened "strike" of doctors, the Health Minister has now sponsored a bill which has no counterpart in any democratic country and which provides for free medicinal care. When fees are to be paid, they are fixed. Even if a sick New Zealander wants his own physician he must pay him the low official allowance, with the result that the private practice of medicine is to be virtually abolished. In principle any government may decide how its medically indigent shall be cared for. It is worth noting that under the dictatorial Bismarck, Germany took the first step toward dealing realistically with the wider distribution of medical care. But private practice was not abolished. Nor did we abolish private schools, colleges and universities, or try to manage them through government officials when we embarked on free education.

Though the bill may be modified as the result of the doctors storm of protest, New Zealand's example should be taken to heart. No sensible person wants to abolish the private practice of medicine in this country, nor is it likely that it will be abolished. But if we are not to go at least part way down the road that New Zealand is evidently bent on following, we shall need to have a practical alternative. Organized medicine itself can, and should, provide that alternative by advocating a policy which will recognize the necessity of a sweeping change in the pattern of medical practice, make the hospital the center of every community's medical activities, bring the best that medicine has to offer to the needy, and permit the public to organize its own medical services under competent supervision. —New York *Times*. (Item in Editorial Column of San Francisco *Chronicle*, December 4, 1941.)

* * *

The Brighter Side*

One of our readers wants to know why we spoke of Sneaky the Flu Germ in the masculine gender, stating that it is a scientific fact that there are both male and female germs. The reader asks if Sneaky could not be a female? The answer is no. Sneaky is definitely of the sterner sex. We have known him for years and could not possibly be mistaken. He wears a black moustache and smokes cigars.

What is more, Sneaky has a wife. We know her, too, so the reader's statement about the germs running in different sexes is no news to us. Mrs. Sneaky is a small Flu Germ of rather timid disposition and, we think, of good heart. When she lights on you it is never in the fiendish manner of her husband. Her attacks are so gentle that folks mention them as "a touch of flu." Sometimes she does not knock you off your pins. When Sneaky lands you think you have been hit by a blackjack.

We believe if Mrs. Sneaky had her way about it she would never bother anybody but would stay at home minding the children and attending to the housework. However, old Sneaky probably grouches around saying she never does anything to help him, a charge that will be familiar to wives who are not even germs, so she finally goes out and lays her "touch" here and there in self-defense against his grumbling.

Some pessimists claim our theory is altogether too altruistic. They say we give Mrs. Sneaky a character that she does not deserve, asserting that there is sinister method in the very lightness of her "touch." It permits the patients to walk around the streets and infest movie houses and streetcars and other place where human beings may be found in groups and spreads her gentle contamination among them in the form of sniffles and small coughs. . . .

We wonder how many of our readers are acquainted with Sneaky's nephew, Bronch Itis, who generally remains on the scene after Sneaky has departed. Bronch Itis is a nasty little guy who delights in keeping you awake by tickling your throat with a feather duster and making you go buh-roop, buh-roop, buh-roop. You let Bronch Itis get in a berth with you in a crowded Pullman and we guarantee that he will not only cause you one of the most uncomfortable nights you have ever known but will win you more enemies than would a speech in favor of Hitler.

If that inquiring reader wants to know why we are so positive about Bronch Itis' sex, we can say that it is because we are dead certain no female could be as ornery as Bronch, even a germ.—San Francisco *Examiner*, December 4.

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*By Damon Runyon. (Copyright, 1941, King Features Synd., Inc.) Distributed by International News Service.

LETTERS†

Concerning Payment of California License Fee by Physician in Military Service of a Foreign Power.

(COPY)

STATE OF CALIFORNIA
Legal Department
San Francisco, November 6, 1941.

Board of Medical Examiners
1020 N Street
Sacramento, California
Attention: Charles B. Pinkham, M. D.
Secretary-Treasurer

Gentlemen:

This is in reply to your letter dated October 20, 1941 and forwarded to this office by the Director of the Department of Professional and Vocational Standards under date of October 28, 1941, in which you request our opinion "as to whether the provisions of Chapter 21, Statutes 1941 are applicable to a licentiate who serves with a foreign power."

The pertinent provisions of the statute to which you refer read as follows:

"Every person licensed under this chapter is exempt from the payment of the annual tax and registration fee in any one of the following instances:

"(a) While engaged in full time active service in the medical corps of the Army, Navy or Marines or in the United States Public Health Service.

"(b) While fulfilling his full time period of training and active service, whether as a draftee or volunteer, under the Selective Training and Service Act of 1940 and any amendments or additions thereto or acts supplementary thereof."

Clearly, one serving with the forces of a foreign power does not come within subdivision (a) above.

With respect to subdivision (b) supra, examination of the Selective Training and Service Act of 1940 (54 Stats. Chap. 720, p. 885) discloses no reference to persons serving in the forces of a foreign power. Consequently, such a person would not be exempt under said subdivision.

It seems clear, therefore, that the legislature intended to exempt from the payment of the annual tax and registration fee only such licensees of your Board as are engaged in the services of this country enumerated as above.

The intent of the statute being clear, it is not for administrative bodies or for the courts to add thereto.

Estate of McDonald, 118 Cal. 277 at 280;
Frinier v. *C. J. Kubach Co.*, 177 Cal. 722 at 727.

It is therefore my opinion that a licensee of your Board serving with a foreign power is not exempt from the payment of the annual tax and registration fee required by Business and Professions Code section 2450.

Very truly yours,
EARL WARREN, *Attorney General.*
(Signed) Thomas Coakley, *Deputy.*

Concerning Registration of Licentiate's Certificate.

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF
PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS
San Francisco, Calif., December 12, 1941.

Yours of Dec. 11th, Re: *Registration of Licenses.*

To the Editor:—In reply to the query propounded by L. A. Hedges, M. D., Secretary of the Contra Costa County Medical Society, beg to advise that for many years past the law has required registration of the licentiate's certificate in whatever county he may practice.

On the back of each certificate issued, in the printed matter is an instruction re this registration.

You will find that section of the law relating to registration i.e., Section 2340 of the P. & P. Code, appears on page 399 of the 1941 directory published by the Board of Medical Examiners.

Conforming with your instruction, we are enclosing a copy of this letter for Dr. L. A. Hedges.

Very truly yours,
(Signed) C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning Civilian Defense Literature on Care of Burns, etc.

(COPY)

OFFICE OF CIVILIAN DEFENSE
WASHINGTON, D. C.
December 18, 1941.

To the Editor:—In reply to your inquiry regarding literature on the care of burns, head injuries, etc., please be advised that the Office of Civilian Defense has cooperated with the American Red Cross and is using their text book for first aid instruction.

As far as the medical profession is concerned it is felt that they will employ the standard procedures as outlined in all acceptable medical texts.

It is contemplated that there will be a booklet issued covering such special subjects as the care of gas wounds and decontamination procedures. This is not available yet but I shall be pleased to advise you as soon as we receive such information. I understand there are some British medical publications covering the subjects but they are difficult to obtain.

Cordially yours,
(Signed) WALLACE D. HUNT, M. D.,
Regional Medical Officer.

Concerning April 6-10 Meeting of the American Congress on Obstetrics and Gynecology.

To the Editor:—In this time of stress, there should be a definite interest in the welfare of the mothers and babies of the nation. The Committee which is sponsoring the next American Congress on Obstetrics and Gynecology, to be held in St. Louis on April 6-10, 1942, represents the only organization outside of governmental bodies which has attempted to unite the efforts of voluntary and other agencies to carry out the widely disseminated plans for the care of women and children. Opportunity for the presentation of advances in obstetric and gynecologic knowledge will be afforded to the many groups interested in these problems at a nation-wide gathering of this kind. The Directors of the project believe that, notwithstanding the war situation, the Congress should be held at the stated time and are proceeding with their plans to make of this an outstanding gathering. Further details of the program will be communicated as these are made available. Inquiries may be addressed to the Central Office, 650 Rush Street, Chicago, Illinois.

Concerning a Bad Check Passer.

Berkeley, Calif., December 29, 1941.

To the Editor:—There is a bad check passer going among the doctors in California and I thought it would be advisable for you to report this in C. and W. M. His approach is a pain around the heart. Knowing he has a mitral murmur the unsuspecting physician is apt to fall into the trap, making a physical examination and prescribing some form of treatment. The trick is after the services have been rendered, without asking the amount of the doctor's fee, he drops a check on your desk made out to him supposedly by his employer, the amount of which is usually $5.00 to $8.00 more than the office fee. He endorses this check and the unsuspecting doctor gives him the balance in change. The man gives his name as John Larabee, the address as 2021 Hearst Street, Berkeley, California. There is no such address.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

He states he is 52 years old and a radio operator. He is 5′ 10½″ tall; weighs 152 pounds; his chest measurements are 34 to 39 inches; waist, 32½ inches; patela reflexes are exaggerated; pupil reflexes, normal; pulse 100; temperature 98; blood pressure 150 over 80; heart position normal, mitral systolic murmur transmitted to the anterior maxillary line; lungs normal; extremities normal. He has an impacted cerumen in both ears, has pyorrhea of all his teeth, a strong odor of tobacco on his breath, and I think I detected the odor of alcohol.

I have seen two of his checks. They are usually made on two different banks. They are made out to J. Larabee; they are signed "Howard E. Bliss." Across the face of the check is written "Compilation" with some number after it like 18 or 200. Then in the corner of the check it is marked "Wages." The checks are all numbered 172 irrespective of the bank they are on.

The publication of this data in the OFFICIAL JOURNAL might catch this fellow, or at least prevent other physicians from being buncoed. This man also pays the druggist with a check instead of using the money the doctor gives him in change.

Yours truly,

(Signed)————————

P.S. This man usually works on Sundays when the banks are closed.

MEDICAL JURISPRUDENCE†

HARTLEY F. PEART, ESQ.
San Francisco

Compensation for Professional Services

THE same general rules are ordinarily held applicable to the recovery by a physician for services rendered to a patient as in the case of a person rendering services of a non-medical nature. To establish his legal right to compensation the physician or surgeon must show that the patient or other person against whom recovery is sought, either expressly or impliedly agreed to pay for such services. In the normal course of the relationship between physician and patient it is seldom that any express contract for payment will be found, and the physician or surgeon must rely for his legal right to remuneration on the implied agreement which the law raises upon the rendition of services that the person benefited thereby will pay their reasonable value. Incidentally it should be noted that before any charge for medical attention will be allowed the physician must be duly licensed to practice medicine under applicable statutes and regulations.

Where a physician is called by one person to give medical care to another.—In this common situation the law has placed many difficulties in the path of the physician or surgeon which may ultimately deprive him of his just fee if he relies for payment on the person calling him. The general rule is as follows: Plaintiff in an action to recover for services rendered a third person brought against the person at whose request they were rendered, must show an express contract to pay since the person sought to be charged has not himself received the care and attention. The implication of a promise to pay the reasonable value of professional services performed is not made in the case where a person requests a physician to render medical attention to another to whom the person making the request is under no legal obligation to furnish medical aid. Even though the recipient of the services may be closely related to the person making the request this will not of itself raise an implied agreement on the part of such person to pay the reasonable value of the services rendered. If, however, the person making the request is legally obligated to support the sick person as in the case of a minor child there is no question as to his liability for medical aid which may be necessary in the course of fulfilling that duty to support. In *McClenahan v. Keyes* (1922) 188 Cal. 574, a case decided some years ago but which still stands as a correct statement of the law today, the court held that a physician could not recover from a mother the value of services rendered her adult daughter in the absence of an express agreement to pay therefore. The same rule has been held to control the case of services rendered to a daughter-in-law. Of course the person who is directly benefitted by receiving the medical attention will be held liable regardless of these considerations.

The promise of a third person to pay for services which have already been rendered another or are in the process of being rendered.—An additional limitation is imposed upon such a promise by the Statute of Frauds providing that where one person guarantees or agrees to answer for the debt of another such agreement or promise must be in writing signed by the person promising before it will be held legally enforceable. The result of this rule is that in order to be certain of collecting his fee when rendering medical services, if the physician is relying on the financial ability of someone other than the person receiving the services, he should exact a written statement from the person from whom payment is expected that he will pay for the services so rendered to another.

The establishment of the amount of the fee to which the physician is entitled.—Assuming that the physician can establish a right to recover his fee against either the person who receives the medical attention or against the person who requests its rendition, the general rule in the absence of an express contract for a stipulated amount is that the physician is entitled to the *reasonable* value of his services. What is reasonable is a question of fact which must be determined upon proper evidence. Ordinarily the physician is entitled to recover the customary charge for similar services rendered by members of the medical profession in the community who occupy the same position as the complaining physician; and testimony of other physicians in the community is admissable to aid the court in arriving at the proper fee.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

If legal action to recover a fee (where there is no express contract) is necessary, the law takes all relevant factors into account.—Of course the obvious factors such as the time devoted to the patient, the nature and complexity of his ailment, the number of visits which the physician makes, the type of operation which the surgeon performs, etc. will be considered by the court in determining what constitutes a reasonable fee in any particular case. In addition to these there are a number of considerations which may be accorded weight where the circumstances of the case in question warrant such treatment. For example it has been held in California and in other jurisdictions that where it is shown that there is a custom or usage among physicians in the community to graduate professional charges with reference to the financial condition and ability of the patient, such financial condition may be considered as affecting the reasonableness of the physician's charges. Other elements of varying importance are the professional standing of the physician, his learning, experience, and skill. In spite of what evidence with respect to the above factors may show, the unpaid physician is aided to some extent in collecting his bill by a presumption in which the court indulges primarily that the amount demanded is not unreasonable and that professional visits were not made unnecessarily.

Provision of Medical Officers For Military Services*

The questionnaires published in recent issues of The Journal elicited many thousands of replies. The requirements of military necessity do not permit stating the exact numbers of names which have been furnished to the Surgeon General at this time or the number who will be requested to come immediately into the service. Appreciation is tendered particularly to the secretaries of state medical societies and to the editors of state medical journals, who gave complete cooperation in circularization of the appeal to the medical profession.

Under Medical Preparedness in this issue of The Journal appears a statement from the Procurement and Assignment Service regarding the present status of needs of the armed services and other federal agencies, and regarding also actions recently taken by the Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians in relation to some questions that have been raised. Every physician in the United States is likely to find before the war is over that special need for his services in some capacity has arisen. The number of physicians to be called into the armed services clearly is sufficiently great to dislocate much of the present status of medical practice. One needs only to point out that the expansion of the Army by another million men would require at least seven thousand additional physicians. An army of four million men would necessitate a total of about thirty-two thousand physicians taken from civilian practice. Moreover, the call is primarily for men under 36 years of age and at most under 45 years of age. On January 15 every medical reserve officer in a governmental department or agency and physically fit was notified that he would be considered available for active duty.

The whole purpose of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians is to provide for the needs of the armed forces with the minimum amount of dislocation of medical service to civilian needs, including public health agencies, industrial plants and medical education. Another primary purpose is to place, as far as possible, men with special qualifications in duties for which they are particularly fitted. These purposes can be accomplished with the complete cooperation of the medical profession. Should the war be prolonged, however, from two to three years the majority of physicians under 45 years of age who are physically fit will be engaged in the military services. Those who are not physically fit to meet the standards of the Army and the Navy will unquestionably be called on for additional services beyond the practices in which they are now engaged. The needs of civilian defense, industry and public health must be met. The Procurement and Assignment Service plans to give to every physician who enrolls with that service for assignment a certificate and a numbered button to indicate that he has made himself available to the nation in this time of emergency. The medical profession can be depended on to do its utmost. Let us not fail!

* Note. This display editorial appeared on page 228 of the JOURNAL A. M. A., in its issue of January 17, 1942.

Provision of Medical Officers For Military Services*

At the time of the Pearl Harbor incident, Dec. 7, 1941, the Army was short approximately fifteen hundred physicians to bring all existing installations up to war strength. Requisition was made on the Procurement and Assignment Service immediately to secure such physicians under the age of 36. The number of physicians in the service was adequate to meet all professional demands in the care of patients but was not sufficient to provide physicians for all organizations on a war strength basis. Therefore the Procurement and Assignment Service on December 18 authorized the publication of application blanks for enrolment with a view to meeting the immediate needs of the Army. These blanks have been circulated by THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and by many state organizations. Some confusion has arisen in that many physicians interpreted the enrolment blank as another call for every physican in the United States to register. Actually, only those ready to volunteer for immediate service were wanted and only the applications of those capable of meeting specified qualifications are being forwarded.

* This important notice appeared in the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (issue of January 17, 1942, on page 231).

The continued registration of all MEN UNDER 36 WHO ARE IMMEDIATELY AVAILABLE for military duty in the Army or the Navy will suffice to meet the immediate needs of the military services, at least until completion of the roster system now being established in the office of the Procurement and Assignment Service.

Within sixty days the Procurement and Assignment Service expects to publish the physical requirements for service with every military, governmental, industrial and civil agency utilizing the services of physicians, dentists and veterinarians. Each physician, dentist or veterinarian will be asked to make a self analysis of his physical condition, so that he may himself determine with which of the agencies he is physically qualified to serve. Shortly thereafter the Procurement and Assignment Service expects to mail a new questionnaire and enrolment form. Each professionally qualified person will be asked to state, first, that he will volunteer his services in the interest of the national emergency; second, to state his first, second, third and fourth choice of the agencies which he will be willing to serve for the duration of the war. A list will be furnished of every military, governmental, industrial and civil agency requiring the services of physicians, dentists or veterinarians.

On self analysis of his physical condition, each man will be thus able to determine whether his physical fitness qualifies him for duty with the requisitioning agencies. On receipt of the enrolment form the Procurement and Assignment Service will issue a certificate of enrolment and a numbered button which will certify that the recipient has offered his services in the interests of the national defense. Thus, those who remain at home in an essential capacity will derive the satisfaction of knowing that they have offered their utmost to the national emergency and that this offer has been formally recognized by the Procurement and Assignment Service.

SAM F. SEELEY, Executive Officer.
MORRIS FISHBEIN, Chairman Committee on Information.
Procurement and Assignment Service.

COMMUNICABLE DISEASES ARE BIGGEST DEFENSE PROBLEM

"Communicable diseases, including those which are primarily pediatric [pertaining to diseases of children] conditions, are a far greater problem of defense and war than are injuries incurred in battle," Wilburt C. Davison, M.D., Durham, N. C., declares in the November issue of *War Medicine*, in an article suggesting a program for combating such conditions. *War Medicine* is a bimonthly publication published by the American Medical Association, Chicago, in cooperation with the Division of Medical Sciences of the National Research Council, Washington, D.C.

"Perhaps in the present emergency a consulting pediatrician who has had experience in preventing communicable diseases among children should be appointed [to the Army]," Dr. Davison says. "In the light of the figures on the frequency of children's diseases in the Army and Navy during the last war, this suggestion is not as foolish as it may seem."

Communicable diseases in both the Army and the Navy of the United States during World War I, he points out, were responsible for more hospital admissions, deaths and days lost than were injuries of battle. One in every 3 soldiers and sailors had one or more of these diseases, and 1 in every 133 in the military and naval services died of infectious disease.

"Although the influenza, pneumonia, bronchitis and tonsillitis of the epidemic of 1918 were responsible for most of the morbidity [illness] and mortality," Dr. Davison says, "half a million soldiers and sailors were affected by the purely pediatric diseases, especially mumps, measles, scabies, rheumatic fever, vaccinia [cowpox], rubella (German measles) scarlet fever, diphtheria, meningitis, dysentry, impetigo and chickenpox, in that order. These twelve children's diseases affected twice as many men in the Army and Navy as did wounds and half as many as did influenza. To reduce this incidence of infectious diseases in troops, pediatricians would recommend the adoption of the preventive measure which have been found to be efficacious for children. Some of these precautions at present are being used in the Army and Navy, but more of them should be applied. . . ."

Dr. Davison makes the following specific recommendations: as soon as a recruit is inducted in the service he should have tests for diphtheria, scarlet fever, tuberculosis and syphilis, be vaccinated against smallpox and be inoculated with typhoid-paratyphoid vaccine and tetanus toxoid or a combined tetanus-diphtheria toxoid. A skin test for sensitivity, of course, should be done first. Alternate recruits should receive influenza vaccine in order that data on its immunizing value may be collected.

"These cutaneous [skin] tests and inoculations," he says, "can be done by the physicians at the induction board's headquarters, and the results can be ready forty-eight to seventy-two hours later by the camp physician and recorded on the recruits' service records."

He also advises that the efficacy of the immunization against diphtheria should be tested three months after the inoculations and that the scarlet fever tests should be repeated annually. If these tests become positive inoculations should be repeated. Regarding tests for tuberculosis, he says that x-ray films of the chest without tuberculin tests are not nearly as accurate in the diagnosis of the disease and he advises that both be used.

Regarding the service records, Dr. Davison advises that the dates of inoculations, the results of the tests and an accurate statement that the recruit has or has not had measles, German measles, chickenpox, mumps, whooping cough, scarlet fever and rheumatic fever be entered thereon. As to the reliability of information on

these diseases obtained from the recruit, he says that the facts can easily be verified by the local draft board from the recruit's parents and family physician during the interval between his placement in class 1-A and his induction. He goes on and says that if there is any doubt about the history, the recruit should be assumed to be susceptible.

"These service records," the author suggests, "should be summarized in advance and lists made of the recruits who are susceptible to each disease, especially mumps and measles, as they affected 353,328 soldiers and sailors in the last war. Usually the percentage of soldiers who have had contagious diseases is low for youths from the country and high for those from cities, because of greater exposure of the latter. However, the crowded school buses of the consolidated country schools may make up for the crowded city streets. . . ."

Regarding objections that may be raised that such elaborate precautions will delay the training program of the recruits, Dr. Davison says among other things that "Surely the 2,482 deaths from measles among the soldiers and sailors in the last war would justify the trial of preventive measures in spite of the time they might consume or the difficulties involved. This plan is not impractical, and the need for speed and other military factors during mobilization should not prevent its utilization for large as well as for small commands. The measures suggested, in addition to reducing the deaths from children's diseases, actually would save time. With the methods used in the last war, which have not been materially changed, 9,374,334 days were lost through children's diseases, quarantine and carrier pogroms (two days per man). Knowing which troops have had and are immune to these diseases will eliminate many erroneous diagnoses and prevent far more loss of time because of unnecessary quarantine than will be taken up by the program outlined. If the 'days lost' are rduced by only 10 per cent, the result will compensate for these precautions. If the yare put into effect, the reduction will be much more than 10 per cent, though even pediatricians are not optimistic enough to expect to eliminate all communicable diseases. . . .

"As an example of the operation of the plan suggested, if measles breaks out a pediatrically trained medical officer will follow the procedure used in most children's hospitals, namely to round up up all possible exposed persons whose records indicate that they have not had measles and to give them convalescent serum, serum and desensitizing if necessary. This is in contrast to the quarantining of thirty-seven of the two hundred and eighteen barracks which was recently done in one of the camps. . . ."

MEDICAL EPONYM

Hunter's Glossitis

The strongly individualistic contributions of Dr. William Hunter (1861-), pathologist to the Charing-Cross Hospital, to knowledge of the nature and causes of pernicious anemia include numerous descriptions of the glossitis that is often identified by his name. The following quotation is from his article, "Further Observations on Pernicious Anaemia (Severe Cases): A chronic infective disease: Its relation to infection from the mouth and stomach: Suggested serum treatment," which appeared in the *Lancet* (1:221-224, 296-299, 371-377, 1900):

> . . . I was struck by the curious character of the sores on the tongue—localised inflamed patches sometimes showing vesicles filled with clear serum situated under the tip of the tongue, the inflamed areas shifting from time to time, with atrophic appearance of the intervening mucosa. The condition thus described is not one of ordinary stomatitis or glossitis such as one meets with as the result of the local irritation of decayed or irregular teeth. . . . Another feature I have had to note is what I may term the "periodicity" of the stomatitis—its variability from time to time, independently apparently of treatment, notably its greater severity at the outset of the disease, usually tending to subside or at least to give less discomfort as the disease advances.—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Landry's Paralysis

Dr. Jean Baptiste Octave Landry (1826-1865) published "Note sur la paralysie ascendante aigue [Note on Acute Ascending Paralysis]" in the *Gazette hebdomadaire de médecine et de chirurgie* (Paris) 6:472-474 and 486-488, 1859). A portion of the translation follows:

> The object of this note is to call attention to a morbid condition that is rather uncommon and generally unknown but deserves a place among the most remarkable diseases in the pathological category.
>
> In these cases, the symptoms, beginning in the extremities, successively involve the upper portions of the body, those more central relatively to the nervous system becoming gradually augmented in intensity in the invaded organs. These symptoms frequently tend to become general, and then produce a definite *general paralysis* with all the characteristics of that of the insane. . . .
>
> I simply add that, nearly always slowly progressive, it occasionally runs a very rapid course, and may become serious or even fatal in a very short time. It is this variety that I propose to designate *ascending* or *acute centripetal paralysis.*—R. W. B., in *New England Journal of Medicine.*

MEDICAL EPONYM

Bundle of His

The original description of this structure, by Wilhelm His, Jr. (b. 1863), is found in the article "Die Thätigkeit des embryonalen Herzens und deren Bedeutung für die Lehre von der Herzbewegung beim Erwachsenen [The Activity of the Embryonal Heart and Its Significance in the Theory of the Contraction of the Adult Heart]," which appeared in *Arbeiten aus der medizinische Klinik zu Leipzig* (14-49, 1893). A portion of the translation follows:

> After prolonged investigation, I have succeeded in finding a muscular bundle that connects the auricular and the ventricular septums. This has hitherto escaped observation because, on account of its small dimensions, it is visible in its entire extent only if this area is cut lengthwise. Up to the present time, I have been able to trace the course of the bundle in such sections and also in serial sections in a grown mouse, a newborn dog, two newborn infants and one adult (thirty years) human being. The bundle arises from the posterior wall of the right auricle near the auricular septum in the atrioventricular groove, continues along the upper margin of the ventricular septum with frequent interlacing of the muscle fibers of the two structures, and then runs forward until, near the aorta, it forks, dividing into a right and left branch. . . .—R. W. B., in *New England Journal of Medicine.*

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XV, No. 1, January, 1917

EXCERPTS FROM EDITORIAL NOTES

The Legislature Meets Soon.—In January the State Legislature will meet. There is considerable evidence that unusual efforts will be made to remove the legal barriers that are designed to protect the public against half-educated practitioners of the healing art. Members of the State Society are strongly urged to get in touch at once with their senators and assemblymen, and remind them that the regular medical profession demands that standards be *not lowered.* We feel it the duty of the State to see that only educated and completely trained physicians are provided for the public. . . .

Malpractice Indemnity Fund.—It is with some degree of satisfaction we are able to announce that the necessary number has been secured to place this scheme in operation. We have now three hundred in the list, and there is a gradual daily increase. . . .

Doctor Philip Mills Jones.—How few of us can do things that others cannot. Were you or I to die tomorrow, what difference would it make? . . .

Work, that is the thing. And how few do work that others cannot; make things, do or write or say things that others cannot.

It was strange to pass the State Society's offices; they had that look of the unknown that sudden and shocking events impart to the most ordinary and intimate objects. To hear a typewriter rattling, and to think of him who used to dictate—to see files and stacks of letters, malpractice suits and judgments coming in, and to think of him whom they used so vitally to interest. To think of the complex fabric of the State Society that he had woven, the JOURNAL, the Medical Defense, and all he had done to bring the profession together, to think of questions critically concerning them, and of what they meant to him—and to us—his work lying undone, and he caring no longer.

Doctor Jones will be missed. Who is there to do his work? to combine law and medicine and his talent for organization; to bring to them an even and justly balanced intelligence, industry and a knowledge of dealing with men?

"To be honest, to be kind"—yes—but more than that—"Work while it is called Today; for Night cometh wherein no man can work."

The Night hath come, and we are groping for a guide

Medicine and Physiology.—A prominent authority, writing a few years back on the failure of internal medicine to advance *pari passu* with surgery, said, and with much truth, that the answer was to be found in the slow growth of physiology. Many of the most fundamental questions are quite unsolved;—the whole story of the work of the liver, the largest cell aggregate in the body; the *modus operandi* of local vascular control, which, if it could be wrested from the subconscious employment of the individual to the conscious direction of the physician would remake the science of treatment; these, and many other great problems, await the answer of the physiologist before internal medicine can be ranged along with chemistry or mechanics in the domain of knowledge. On the other hand, it is unfortunately true that the average practitioner pays little attention to physiology after leaving college. . . .

(Continued on Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

Charles B. Pinkham, M. D., Secretary-Treasurer of the Board of Medical Examiners of the State of California, reports results of the written examination held in Sacramento, October 21 to 23, inclusive, 1941. The examination for physicians and surgeons covered nine subjects and included ninety questions. An average of 75 per cent is required to pass. Seventy-nine applicants wrote the examination. Included in the applicants were several graduates of foreign medical schools.

The highest mark for physicians and surgeons (86-7/9 per cent) was made by Harry Andre Melvin, M. D., Southern Pacific Hospital, San Francisco, California, a graduate of the University of Oregon Medical School, June 6, 1941.

The following is a list of successful applicants:

NAME	SCHOOL
Alsberg, Julius Peter *Germany*	U. of Hamburg, '19
Anderson, Melvin Walter *Santa Barbara*	U. of Oregon Med. Sch., '39
Bailey, Nicholas Edward *Orange*	U. of Nebraska Coll. of Med., '41
Barr, Robert Maurice *National City*	Coll. of Med. Evang., '41
Briggs, Barton Eugene *San Francisco*	Boston U. Sch. of Med., Mass., '41
Burton, Thomas Philip *San Francisco*	U. of Illinois Coll. of Med., '41
Campbell, Macia *San Francisco*	U. of Toronto Fac. of Med., Canada, '40
Cannon, Jesse F. *Oakland*	George Washington U. Sch. of Med., D.C., '41
Crookston, Wayne Gilbert *Salt Lake City, Utah*	U. of Pennsylvania Sch. of Med., '39
Culiner, Norman W. *San Francisco*	U. of Toronto Fac. of Med., Canada, '41
Englund, DeWitt Walter *Orange*	U. of Minnesota Med. Sch., '40
Feder, Ellen Wynne Posnjak *Los Angeles*	George Washington U. Sch. of Med., D.C., '40
Fisher, Russell Virgil *Glendale*	Coll. of Med. Evang., '41
Friedlander, Ernst *Austria*	U. of Vienna, '14
Friedrich, Leland Edward *Oakland*	U. of Wisconsin Med. Sch., '41
Garthwaite, Mary Elizabeth *San Francisco*	U. of California Med. Sch., '41
Glickman, Milton *Beverly Hills*	Loyola U. Sch. of Med., Ill., '40
Gummess, Glen Hall *Atascadero*	Harvard U. Med. Sch., Mass. '38
Jensen, William Elmer *San Francisco*	Creighton U. Sch. of Med., Nebr., '41
Kearns, Grant Franklin *Pasadena*	Northwestern U. Med. Sch., Ill., '41
Keller, Virginia Inadine P. *Glendale*	Northwestern U. Med. Sch., Ill., '39
Knecht, Rudolf *Los Angeles*	U. of Vienna, Austria, '25
Koerper, Victor Eugene *Santa Rosa*	U. of Rochester Sch. of Med. & Dentistry, N. Y., '40
Kohlmoos, Heinrich Walter *Oakland*	Stanford U. Sch. of Med., '41
Kollmann, Walter *San Francisco*	U. of Vienna, Austria, '28
Kusayanagi, Masako *Los Angeles*	U. of So. Calif. Sch. of Med., '41
Larsen, Loren J. *Oakland*	Rush Med. Coll. of the U. of Chicago, Ill., '41
Libbey, Charles Warren *Oakland*	Georgetown U. Sch. of Med., Washington, D. C., '41
Lighter, Andrew George *Atlanta, Ga.*	Royal Hungarian Elizabeth U. of Science, '26
Loewenthal, Max *Berkeley*	U. of Berlin, Germany, '21
Melvin, Harry Andre *San Francisco*	U. of Oregon Med. Sch., '41
Mikita, Michael M. *Oakland*	Rush Med. Coll. of U. of Chicago, Ill., '41
Mitchell, Howard *San Francisco*	U. of Toronto Fac. of Med., Canada, '41
Nelson, Waldo Ray *Loma Linda*	Coll. of Med. Evang., '41

(Continued in Back Advertising Section, Page 38)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.